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THE EFFECTS OF GENDER ROLE CONFLICT, STIGMA, AND SOCIAL SUPPORT ON
HELP-SEEKING IN MALE SERVICE MEMBERS

by

Lindsay Danforth

A Dissertation Submitted in

Partial fulfillment of the

Requirements for the Degree of

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in Education Psychology

at

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August 2016

ABSTRACT

THE EFFECTS OF GENDER ROLE CONFLICT, STIGMA, AND SOCIAL SUPPORT ON HELP-SEEKING IN MALE SERVICE MEMBERS

by

Lindsay Danforth

The University of Wisconsin-Milwaukee, 2016
Under the Supervision of Professor Stephen R. Wester

It is a well-documented fact that men tend to seek professional help less frequently than women. Several factors might affect one's help seeking behaviors, including gender role conflict, stigma, and perceived social support. This study served to examine help-seeking in male service members; more specifically, it explored how the above mentioned factors influenced attitudes and intentions towards seeking help. It also assessed whether or not the Gender Role Conflict Scale acts as a microcontextual primer. The data was analyzed using a structural equation modeling procedure. Results indicated a poor fit of the model to the data. Results also suggested that the Gender Role Conflict Scale does, indeed, serve as a microcontextual primer. Implications of these findings are discussed. Limitations of the study and suggestions for future research are also provided.

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Chapter I

INTRODUCTION

Significance of the Problem

It has been well-noted that men tend to have negative attitudes towards seeking professional help for the problems faced in their lives- a fact that is held true regardless of individual characteristics or type of problem (Addis & Mahalik, 2003). Indeed, seeking help for any type of issue, especially a psychological issue, might threaten the socially conceived standards that exist for men (O'Neil, 2008). The very idea of therapy seems to go against male gender norms that have been set in place. In today's society, men are taught to be powerful, independent, and always in control. Furthermore, they are taught to be emotionally restrictive, as well as capable of solving their own problems. If a man were to seek help, it could damage his sense of masculinity, as well as his self-esteem. Moreover, the mere fact that he was asking for help might make him feel dependent on someone other than himself. He would be forced to relinquish some of his power to the therapist, and he would feel that he was no longer fully in control of the situation.

This same reluctance towards seeking professional psychological help exists for service members in the military. While veterans make up less than one percent of the population (Plach & Haertlein Sells, 2013), they are a population whose unique characteristics must be taken into account when providing professional psychological help. According to Bryan, Clemans, & Hernandez, (2012), "[t]he military culture values strength, resilience, courage, and personal sacrifice in the face of adversity" (p. 98). Similar to the military culture, traditional Western masculinity also values many of these same characteristics. While deployed, these characteristics are often adaptive and necessary for survival for service members. They can become

problematic, however, when service members return home and are in need of professional psychological services (Danforth & Wester, 2014). The act of seeking help would not only go against the traditional masculine culture they have been socialized to follow, but the military culture as well. Service members tend seek professional help at low rates (Blais & Renshaw, 2013; Williamson & Mulhall, 2009), and they are also at high risk of terminating prematurely (Danforth & Wester; Williamson & Mulhall).

For young adults, psychological distress often impacts one's employment, academic success, and substance use (Nam et al., 2012). This point is exacerbated for service members, who face a number of additional challenges in transitioning to college. As of 2010, over 210,000 veterans have taken advantage of the GI bill in order to receive a college education (Elliott, Gonzalez, & Larsen, 2011). The Post-9/11 GI Bill provides veterans who have served at least 90 days of active duty, their spouses, and their children with the opportunity to receive college degrees. According to Plach and Haertlein Sells (2013), it is important to consider this generation of service members in particular because they face a unique set of challenges in transitioning home as compared to service members from previous wars. For instance, there has been significant advancement in both medical treatment and protective gear worn by service members. In addition, there has been an increase in suicide bombers and IEDs, which has led to more traumatic brain injuries (TBIs) than in previous wars (Plach & Haertlein Sells). This is also the first war that has continued for an extended period of time that has relied solely on volunteer service members. As such, certain risk factors including "(1) the length of deployment (sometimes 12-15 months), (2) multiple deployments (some service members have been to Iraq three or four times), and (3) sleep deprivation" (Plach & Haertlein Sells; p. 74) may have serious implications for returning veterans.

Additionally, the transitional challenges that they face while adjusting to college are different than the transitional challenges of their civilian peers. Service members who decide to pursue a college degree often face a number of challenges upon entering school. For instance, there are institutional and/or structural challenges they might face, including creating their own schedule and “being their own bosses” (Elliott et al., 2011). There are also interpersonal challenges they may face, including trying to fit in with students who are much younger than they are, or being surrounded by those who are far less respectful of authorities. Lastly, there are physical and mental challenges they may be facing. OEF/OIF service members have a greater chance of surviving as compared to those from previous wars, due to the advancements of medical treatment and armor (e.g., Elliott et al.; Plach & Haertlein Sells, 2013).

In their study on needs for veterans on college campuses, Plach and Haertlein Sells (2013) found that 23% of their sample screened positively for PTSD, 77% of the sample screened positive for possible depression, and 53% screened positive for problematic drinking. Upon further investigation, the authors found that 43% of the sample met criteria for alcohol dependence, 66% drank harmfully, and 93% of the sample drank hazardously. This suggests that there is a need for psychological help for service members on college campuses. While this need exists, and while there are campus services designed to help service members and veterans, service members are often reluctant to seek the help that is available on college campuses and in the community.

One factor that has been identified as a significant barrier to seeking professional help for men is stigma (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012; Nam et al., 2012; Pederson & Vogel, 2007; Vogel, Wester, & Larson, 2007). There are two types of stigma: public stigma and self-stigma (Pederson & Vogel, 2007). While both influence attitudes and intentions towards

help-seeking, research demonstrates that self-stigma has more of a negative impact on seeking psychological help (Nam et al.). Stigma has also been identified as a barrier to help-seeking for service members (e.g., Brooks, 1998; Danforth & Wester, 2014; Skopp et al., 2012). The cost of professional cost of seeking professional help is particularly high for this population (Danforth & Wester; Wester & Lyubelsky, 2005; Wester, Arndt, Sedivy, & Arndt, 2010). As Danforth and Wester (2014) note, service members “face additional concerns in the form of fears about being labeled as unfit for duty, or having a history of psychological service made part of their permanent record thereby affecting mission status and potential promotion” (4).

Another documented reason for men’s negative attitudes towards help- seeking is high gender role conflict (Good, Dell, & Mintz, 1989; O’Neil, 1986; O’Neil, 2008; Pederson & Vogel, 2007; Wester et al., 2010). According to O’Neil (2008), there are four patterns of gender role conflict: Success/Power/Competition (SPC), Restrictive Emotionality (RE), Restrictive Affectionate Behavior Between Men (RABBM), and Conflict Between Work and Family Relations (CBWFR). Increased levels of gender role conflict (GRC) have been associated with more negative attitudes towards therapy (Good, Dell, & Mintz; Pederson & Vogel; Rochlen & O’Brien, 2002; Wester et al.), perhaps because the internal conflict experienced by men with higher GRC interferes with their ability to process central messages about the possible benefits of therapy.

In their seminal work, Jones and Heesacker (2012) discuss the idea of microcontexts and how these environmental situations might affect gender role conflict. Their study on the effects of microcontexts on gender role conflict found that scores on the Gender Role Conflict Scale differed between primed and unprimed participants. This suggests that situational contexts may, in fact, explain variations in gender role conflict scores and in scores related to help-seeking.

While Jones and Heesacker posited that the GRCS may, in fact, act as a microcontext in and of itself, this has never been tested in the literature.

In recent decades there has been significant movement made toward understanding ways in which this reluctance to seek psychological help can be overcome. Research has suggested that perceived social support may be an important element in explaining the gender disparity in help-seeking behavior (Vogel, Wade, Wester, Larson, & Hackler, 2007). Said another way, men's lower rates of seeking psychological help may be in large measure the result of the support- or lack thereof- that they receive from their friends and family regarding the act of seeking psychological help. Research on social support suggests that it may serve as a mediator between stressful life events and psychological consequences, and that it increases adaptive coping behaviors in individuals when they face stressful situations (Wester, Christianson, Vogel, & Wei, 2007). In effect, social support serves as a buffer between the negative outcomes potentially experienced as a result of life events. Social support is also an integral component of success for service members on college campuses. This support includes connecting them with other service members on college campuses, as well as institutional support from faculty, offices on campus, etc. (Plach & Haertlein Sells, 2013). Similarly, Whiteman, Barry, Mroczek, and MacDermid Wadsworth (2013) found that perceived emotional support was associated with both better academic and mental health outcomes for veterans and civilian students.

Although gender role conflict, stigma, social support, and attitudes toward seeking help have been individually studied in the psychology of men literature, no published work specifically tested any linkages between these variables has been located in the literature. Furthermore, no study has examined all of these variables in male service members.

Statement of the Problem

Research has consistently demonstrated that service members often do not seek help for psychological distress (e.g., Blais & Renshaw, 2013; Williamson & Mulhall, 2009). This creates a “service gap” (Nam et al., 2012) between those who are most in need of treatment and those who are willing to seek professional help. Certain factors- such as public stigma, self-stigma, and gender role conflict (GRC)- have been identified in the literature as barriers to seeking psychological help (e.g., Good, Dell, & Mintz, 1989; O’Neil, 1986; O’Neil, 2008; Pederson & Vogel, 2007; Wester et al., 2010) while other factors- such as social support- have been identified as facilitators to help-seeking. It is important to understand the relationships between these variables in service members in order to better comprehend perceived barriers and facilitators to care, and how they influence one’s willingness to seek help. To date, however, no single study has considered how all of these factors influence service members’ attitudes towards seeking help.

Research Questions and Hypotheses

The purpose of this study is two-fold. Its first purpose is to examine the relationships between GRC, stigma, social support, and help-seeking in male service members. The second is to determine whether the GRCS is, indeed, a primer. In order to increase positive attitudes towards seeking psychological help and willingness to seek help, we must first understand the factors that influence these attitudes. The goal of this study is to determine whether gender role conflict, stigma, and social support predict positive attitudes towards seeking psychological help in male service members on a college campus. More specifically, this study will test a model in which social support and stigma mediate the relationship between gender role conflict and help-seeking.

Research Questions

1. Does social support mediate the relationship between GRC and help-seeking in male service members?
2. Does stigma mediate the relationship between GRC and help-seeking in male service members?
3. Can the Gender Role Conflict Scale (GRCS) act as a primer?

Hypotheses

1. Social support will mediate the relationship between gender role conflict and help-seeking in male service member college students in that the higher the gender role conflict score, the less willing participants will be to seek help.
2. Stigma will mediate the relationship between gender role conflict and help-seeking in male service member college students in that the higher the gender role conflict score and the stigma score, the less willing participants will be to seek help.
3. The placement of the Gender Role Conflict Scale will negatively influence one's scores related to attitudes towards help-seeking as well as intentions to seek help. Said another way, the GRCS will produce different scores in participants based on where in the questionnaire it is.

Definition of Terms

Gender role conflict (GRC): “a psychological state in which socialized gender roles have negative consequences for the person or others” (O’Neil, 2008; 362).

Military: “the armed forces of the United States as defined in title 10 of the United States Code and specifically charged with the protection of this country and the defense of its interests both foreign and domestic” (Danforth & Wester, 2014; p. 2)

Public Stigma: “the reaction of the general public toward individuals with mental health problems” (Skopp et al., 2012; p. 1037).

Self-stigma: “the reduction of an individual’s self-esteem or self-worth caused by the individual self-labeling herself or himself as someone who is socially unacceptable” (Vogel, Wade, & Haake, 2006; p. 325).

Service member: members of the armed forces

Social support: “the process whereby people manage social resources... to enhance and compliment their personal resources for meeting demands and achieving goals” (Wester et al.; 2007, p. 216).

Stigma: “the perception of being flawed because of a personal or physical characteristic that is regarded as socially unacceptable” (Vogel, Wade, & Haake, 2006; p. 325)

Veteran: “those who have served in the U.S. military, but have since separated from that service” (Danforth & Wester, 2014; p. 2)

Chapter II

LITERATURE REVIEW

Introduction

Research suggests that the rates of help-seeking for men are significantly lower than the rates of help-seeking for women, and that this fact is held true regardless of individual characteristics and type of problem faced (Addis & Mahalik, 2003; Mansfield, Addis, & Courtenay, 2005). This is also true for service members who seek help at rates lower than that of their civilian counterparts and who are at risk for prematurely terminating (Blais & Renshaw, 2013; Danforth & Wester, 2014; Williamson & Mulhall, 2009). Indeed, only a small percentage of service members who are experiencing psychological distress choose to seek help (e.g., Hoge et al., 2004), thereby creating a “service gap” between those who are in most of need of psychological treatment and those who are actually willing to seek professional help when they experience psychological distress (e.g., Nam et al., 2012). Certain factors- such as gender role conflict, public stigma, self-stigma, and social support- have been identified in the literature as barriers or facilitators to help-seeking (Mittal et al., 2012; Nam et al.; O’Neil, 2008; Wester et al., 2010; Whiteman et al., 2013). No study to date, however, has considered how all of these variables interact in order to affect a man’s attitudes towards help-seeking, as well as his willingness to seek help. Furthermore, no study has examined all of these variables in service members.

In order to understand the factors influencing one’s attitudes and intentions towards seeking help, this researcher conducted a literature review focused specifically on gender role conflict, stigma, social support, service members, and help-seeking. The following databases were utilized in order to find relevant articles: PsycINFO, Google Scholar, WorldCat, and ERIC.

In addition to using electronic databases and the University of Wisconsin-Milwaukee library, the reference lists from relevant articles were also used in order to find additional relevant materials. Specific terms- such as “gender role conflict”, “stigma”, “public stigma”, “self-stigma”, “perceived social support”, “veterans”, and “service members”- were used in order to search for relevant publications. This researcher tried to utilize research on help-seeking, gender role conflict, stigma, social support, and service members from the last 20 years, but also included important literature from earlier years.

Help-Seeking

Research in the psychology of men and masculinity literature has consistently demonstrated that men seek help less frequently than women for problems they may be facing, including depression, substance abuse, posttraumatic stress disorder, and physical ailments (Addis & Mahalik, 2003; Mansfield, Addis, & Courtenay, 2005). Furthermore, this fact is held constant across race/ethnicity, socioeconomic status, and age (e.g., Addis & Mahalik; Courtenay, 2000; Morgan & Robinson, 2003). According to Vogel, Wester, and Larson (2007), less than one-third of men experiencing psychological distress seek help, and it is often seen as a last resort after all other options have failed. The authors note that men who do choose to seek help “are more likely to rate their level of distress as extreme or severe” (413) as compared to their female counterparts. If they are using counseling as a last resort, it is likely that they have tried to find other ways to solve the problem (i.e. ignoring it or working through it alone), and that these alternative ways have failed them. Therefore, by the time they come in, they have been dealing, unsuccessfully, with this issue for a while. In addition to seeking help less frequently, research also suggests that men are less likely to recognize and label feelings of psychological distress as

problematic when compared to women (Addis & Mahalik). This difficulty may also contribute to not seeking help until their symptoms are extreme or severe.

Those who work in the area of men and masculinity have developed several theories- such as gender role socialization, gender role conflict, and stigma- to explain this reluctance towards seeking professional help. Indeed, Addis and Mahalik (2003) state that, when considering the help-seeking behaviors of men, it may be helpful to view them “as a product of masculine gender-role socialization” (7). This socialization teaches men from a young age to be self-reliant, physically tough, and emotionally stoic (O’Neil, 2008; Wester & Lyubelsky, 2005). For a man, admitting that he is experiencing psychological distress and is in need of professional help goes completely against the values that the traditional masculine culture has instilled in him. In addition to the aforementioned reasons, other factors may affect a man’s ability to seek help. For instance, men from lower socioeconomic statuses are frequently not able to seek help because they cannot afford healthcare (Mansfield, 2003). There are other barriers to seeking care, such as not being aware of treatment options, not understanding the treatment process, or not having time in one’s schedule, which may also impede an individual’s willingness to seek professional help (e.g., Britt et al., 2008). As Wester and colleagues (2010) note, there is an “unsettling paradox” (288) in that those who are highest in gender role conflict and who would benefit the most from therapy are more likely to stigmatize seeking help and avoid it.

Morgan and Robinson (2003) focused specifically on the help-seeking behaviors of college students and looked at how gender, racial background, and student status affected help-seeking. Their sample consisted of 194 college students from a Canadian University. Approximately 53% of the sample was female and 47% of the sample was male. The authors found that there was a significant differences in gender with regards to help-seeking in that

women held more positive attitudes towards seeking help and they had greater intentions to seek help as well. One interesting finding that the authors discuss was that men reported lower distress levels than female participants. As the authors mention- and as others (e.g., Addis & Mahalik 2003) have also noted- it is possible that the male participants were either under-reporting their symptoms or it may have been due to their inability to appropriately label their distress.

Morgan and Robinson (2003) also found a significant difference in race/ethnicity with regards to help-seeking behaviors in that Caucasian participants held the most favorable attitudes towards seeking help, and were more likely to do so as compared to Asian students. They did not discuss attitudes towards help-seeking with any other racial groups in the study and did not talk about how help-seeking varied outside of Caucasian and Asian students. The authors make a notable claim that decisions to seek professional help may, in part, be due to the type of problem students are facing. More specifically, they found that participants had more positive attitudes towards career counseling than traditional counseling for a personal problem. This suggests that students- particularly male students- may be more comfortable with more nontraditional forms of help, a finding that is consistent with previous research in the field of men and masculinity (e.g., Rochlen & O'Brien, 2002).

In their study on barriers to seeking help, Mansfield, Addis, and Courtenay (2005) sought to create a scale that captures some of the barriers to seeking help for men. The purpose of their study was not only to understand how gender role conflict and various social processes affect one's perceptions of barriers to care, but to also create and the Barriers to Help-Seeking Scale (BHSS). Their first study was intended to identify items for the BHSS, while the second study was intended to validate the items on the BHSS by correlating it with the Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH). Their first sample consisted of 537

male undergraduate students from a Midwestern University and their second sample consisted of 58 male undergraduate students from a Northeastern University.

After creating the BHSS, Mansfield and colleagues (2005) found that their Emotional Control subscale correlated with the Restrictive Emotionality, Restrictive Affectionate Behavior Between Men, and the Success, Power, and Competition subscales of the Gender Role Conflict Scale (GRCS). The authors also found that there was a large correlation between all GRCS subscales and the Minimizing Problem and Resignation subscale, which led them to suggest that minimizing problems may somehow be related to GRC. Interestingly, Mansfield et al. found differences in correlations between the BHSS and the GRCS with the two samples they used. The authors found that the correlations between the BHSS and the GRCS were larger for participants from the Midwestern sample when compared to the sample from the Northeast. Since the Midwestern sample was collected from a conservative, religious college and the Northeastern sample was collected from a liberal college, the authors posited that the BHSS might present “more of a threat to masculinity for conservative populations than for liberal ones” (105). While this may be the case, it is important to note that the sample from study two was almost one third of the size of the sample from study one, so it is not surprising that the correlations were larger.

The issue of help-seeking becomes more concerning when one considers service members. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 18.5% of veterans returning from Iraq or Afghanistan meet criteria for PTSD or depression (SAMHSA, 2011), and the suicide rate for service members is significantly higher than that of the civilian population (Bryan et al., 2012; Burns & Mahalik, 2011). This suggests a strong need for psychological services, yet rates of help-seeking for

veterans are often very low. Similar to masculine culture, the military culture sends messages to service members that experiencing psychological distress- and seeking professional help for said distress- are potentially problematic (Danforth & Wester, 2014). As previously mentioned, characteristics such as self-reliance, achievement, physical toughness, and emotional stoicism are endorsed by traditional Western masculine culture (Wester & Lyubelsky, 2005). Military culture values and instills similar characteristics in service members in addition to characteristics such as resilience, courage, and collectivism (Bryan et al.; Danforth & Wester). Service members are also expected to be mentally tough, meaning that they are expected to “to suck it up and find ways to manage their personal problems on their own without having to admit weakness or bring risk upon themselves or members of their team” (Danforth & Wester, p. 2).

Research suggests that 56% to 87% of veterans who experience psychological distress do not seek help (Blais & Renshaw, 2013), and only half of those who seek treatment receive what they consider to be adequate care (Williamson & Mulhall, 2009). The rate of help-seeking is even lower when one specifically focuses on male service members who seek help even less frequently than female service members (e.g., Vogel, Wester, & Larson, 2007). Furthermore, research suggests that service members are more likely to under-report symptoms associated with psychological distress, are less likely to seek professional help when experiencing these symptoms, and are more likely to prematurely terminate after the first session (Danforth & Wester, 2014; Weiss, Coll, & Metal, 2011). For many veterans who do seek help from civilian providers, premature termination occurs because they feel that civilian providers do not understand what they have experienced or their worldviews (Cogan, 2011).

Nam et al. (2012) conducted a meta-analysis on factors that influence one’s attitudes towards seeking professional psychological help. These factors included- among others- self-

stigma, public stigma, and social support. Their meta-analysis consisted of 19 studies which included a total of 7,396 participants. The authors found that certain factors- such as social support- were positively related to help-seeking. Other factors- like public and self-stigma- were negatively related to help-seeking. The authors found that there was a range of effect sizes for the variables associated with one's attitude towards seeking help. Self-stigma had a large effect size ($r > .40$), public stigma had a medium effect size ($.20 < r < .40$), and social support had a small effect size ($r < .20$). Their findings suggest that self-stigma is one of the strongest variables associated with help-seeking since it accounts for at least 40% of the total variance of attitudes scores.

When considering help-seeking behaviors of male service members, it is important to understand the unique intersection between military culture and masculine culture (Danforth & Wester, 2014), and how it may influence their attitudes towards seeking help. It is possible that having a greater understanding of how these two aspects of male service members' identities may help to increase attitudes towards seeking professional help, as well as intentions to seek help. In their article on considerations for gender-sensitive therapy with male veterans, Danforth and Wester highlight some of the unique challenges faced by male veterans that may impede their decisions to seek help. For instance, veterans may not seek professional psychological help for fear of how others will perceive their decision to do so. They may fear being looked at as weak or crazy by others they have served with, by family, or by their friends (e.g., Bryan et al., 2012; Danforth & Wester). Additionally, the notion of a "warrior ethos" (Bryan et al.), which stresses characteristics such as honor, duty, selfless service, and "courage in the face of adversity" (Bryan et al.; p. 98), may prevent service members from seeking help when they experience psychological distress since they may think they need to deal with their own

problems. Indeed, research has demonstrated a relationship between attitudes towards seeking psychological help and both stigma gender role conflict (GRC). While other factors certainly may influence one's attitudes towards help-seeking, these two have consistently exhibited a significant relationship with help (e.g., O'Neil, 2008; Vogel et al., 2013; Vogel, Wester, & Larson, 2007). As such, this dissertation will focus specifically on these two variables, along with social support, which may positively influence one's decisions to seek professional psychological help.

Stigma

Research has demonstrated that there is a significant negative relationship between stigma and both attitudes towards seeking professional help and intentions to seek help (Eisenberg et al., 2009; Vogel et al., 2013). Vogel, Wester, & Larson (2007) point out that stigma is not only attached to having a psychological disorder and/or experiencing psychological distress, but it is also attached to the actual act of seeking help. Research distinguishes between two dimensions of stigma: public stigma and self-stigma, both of which have been identified as barriers to seeking psychological help (e.g., Skopp et al., 2012; Vogel, Wade, & Haake, 2006; Wester et al., 2010).

According to Mittal et al. (2012), the literature on self-stigma suggests there is a hierarchy- referred to as the "three A's" (974): awareness, agreement, and application. Awareness refers to one's knowledge of particular stereotypes (i.e. men who seek help are weak). Agreement refers to the degree to which an individual agrees with said stereotypes (i.e. it may be very salient for a man who was raised to follow traditional Western masculine gender norms). Lastly, application refers to an individual applying said stereotypes to themselves (i.e. a man believing that he is weak because he has sought professional psychological help instead of

solving his own problems). Self-stigma in particular has been identified as one of the major barriers to help-seeking for men (e.g., Vogel et al., 2006; Wester et al., 2010). Since men are taught to be self-reliant and emotionally stoic, admitting that they cannot handle their own psychological distress may imply that they are not capable of solving their own problems or that they are weak. This may, in turn, make them feel as if they have somehow failed in terms of their masculinity, which would result in lowered self-esteem. As such, even if men would benefit from therapy, they often avoid it for fear of being viewed negatively by others (e.g., Vogel, Wester, & Larson, 2007).

Vogel, Wester, and Larson (2007) state that those in their 20's who have college education tend to have more positive attitudes towards therapy and towards seeking help. The authors state that college "may be an environment in which seeking help is seen more favorably than it is in other environments" (415). In their study on stigma and help-seeking in college students, Eisenberg and colleagues (2009) wanted to explore this idea further. They noted that college campuses provide a unique environment to reduce barriers since most disorders have an onset before the age of 24, psychological distress experienced earlier on in life negatively impact all aspects of functioning (i.e. interpersonal, academic, occupational), and college taps into so many aspects of students' lives (i.e. academic, social, residential). They also discussed how interventions geared towards increasing positive attitudes towards help-seeking in college students can have substantial and long-term benefits.

Like others (e.g., Vogel, Wade, & Hackler, 2007; Vogel et al., 2013), Eisenberg et al. (2009) believed that self-stigma is derived from first experiencing public stigma. They posited that perceived public stigma could impact one's willingness to seek help in that they would want to avoid criticism or discrimination for using professional services. Eisenberg et al. looked at

public stigma and personal stigma, which they defined as “the aggregate of each individual’s stereotypes and prejudices” (2) instead of focusing on self-stigma because they believed that personal stigma was relevant to those who were experiencing mental health problems, as well as those who were not experiencing mental health problems. Previous studies have found that experiencing more personal stigma is associated with lower rates of seeking help, which is similar to studies that have found a negative relationship between self-stigma and help-seeking. Research exploring the relationship between perceived public stigma and help-seeking has found mixed results. The authors cite one study which found a negative relationship between public stigma and treatment adherence. Furthermore, those who perceived more public stigma were more likely to prematurely terminate. Other studies have found no significant relationship between perceived public stigma and help-seeking (i.e. Golberstein, Eisenberg, & Gollust, 2009).

The study’s sample was comprised of 5,555 undergraduate and graduate students from 13 schools across the county. They found that rates of perceived public stigma were significantly higher than personal stigma, rates of personal stigma were higher for certain participants (most notably those who were male and younger), and that there was a negative relationship between personal stigma and help-seeking. One interesting finding from their study was that almost all of the students who had high personal stigma also had high perceived public stigma. This again demonstrates that there is a link between public and self-stigma in that “personal attitudes are significantly shaped by prevailing public attitudes” (14). While a lot of the extant research suggests that younger students may hold more favorable attitudes towards seeking help, Eisenberg and colleagues’ research did not support that. They point out that young adults tend to report more stigmatizing views and seek help less frequently than older adults. The authors state

that interventions designed to reduce stigma should be “targeted and tailored to the attitudes and behaviors of specific student populations” (15).

One significant limitation of this study was how the authors chose to measure help-seeking. No actual measure- such as the Attitudes Towards Seeking Professional Psychological Help Scale or the Intentions to Seek Counseling Inventory- were used in this study. The authors merely asked if participants thought they needed help for a psychological problem over the last 12 months. While the authors did find a significant relationship between stigma and help-seeking, asking participants if they thought they needed help for a psychological problem in the last year does not sufficiently address the issue of help-seeking. For instance, it does not address their attitudes towards the actual act of seeking help, nor does it address their actual intentions to seek help if they did perceive a problem.

Similar to Eisenberg et al. (2009), Vogel and colleagues (2013) believed there was a relationship between public stigma and self-stigma, and believed this relationship could be explained through the use of Modified Labeling Theory (MLT). MLT posits that self-stigma is the byproduct of people internalizing public stigma over an extended period of time. In order to test this idea, the authors used a repeated-measures design where they measured perceptions of public and self-stigma in participants and then measured it again three months later. Their sample consisted of 448 college students, 67% of whom were women. Vogel et al. found that higher public stigma scores at Time 1 predicted higher self-stigma scores at Time 2. The opposite was not true, however, meaning that higher self-stigma scores at Time 1 did not predict higher public stigma scores at Time 2. These findings provide support for the Modified Labeling Theory in that public stigma is internalized over time and becomes self-stigma. The authors note that their results provide further evidence that self-stigma is more closely related to attitudes

towards help-seeking and intentions to seek help than public stigma. It would be too difficult to address the issue of public stigma, but perhaps addressing the issue of self-stigma may increase positive attitudes and willingness to seek help.

Vogel, Wade, and Hackler (2007) held a similar position with regards to targeting interventions specifically to focus on self-stigma rather than public stigma since it would be rather difficult to change society's perceptions of mental health. They sought to understand the relationship between public stigma, self-stigma, attitudes towards help-seeking, and willingness to seek help. There were 680 undergraduate participants in their study, 50% of whom were male. The authors found that there was a significant positive relationship between public stigma and self-stigma, suggesting that higher scores of public stigma predict higher scores of self-stigma. They also found that there was a significant negative relationship between self-stigma and attitudes towards seeking help in that the higher one's self-stigma score, the more negative their attitude towards seeking help was. Additionally, they found a significant positive relationship between attitudes towards counseling and willingness to seek counseling, suggesting that the more positive one's attitudes are towards seeking help, the more willing they will be to seek help. Lastly, they found that both self-stigma and attitudes towards seeking help mediated the relationship between public stigma and willingness to seek counseling. These results also provided support for Modified Labeling Theory.

There are a couple of notable limitations of Vogel et al.'s (2007) study. First, with regards to demographics, half of the sample was comprised of first year students. It is possible that, as one gets older, their perceptions of public stigma or self-stigma may decrease (Eisenberg et al., 2009). Second, the authors did not consider how gender role socialization may impact both

public stigma and self-stigma. It is possible that, for male participants, they were less willing to seek help because of other factors associated with masculinity (i.e. self-reliance).

Golberstein and colleagues (2009) also studied the longitudinal effects of perceived public stigma on perceptions of needing help. They stated that, in addition to negative attitudes towards mental health care, perceived public stigma has also been linked to negative outcomes in healthcare settings, such as decreased medication adherence. In a previous study, the authors found that, for students younger than 22, greater perceived public stigma was associated with lower perceptions for needing help, and there was no significant difference for older students. In the current study, the authors wanted to specifically explore the long-term effects of perceived public stigma. Their sample consisted of 732 undergraduate and graduate students who participated in the Healthy Minds Study. These participants completed the initial survey in 2005 and then completed the follow-up survey in 2007.

Golberstein et al. (2009) did not find support for the idea that public stigma affected students' perceptions of need for help. The authors noted that they did not take into account all aspects of stigma; most notably missing from the study was self-stigma. As previously mentioned, other research has found that, over long periods of time, perceived public stigma can become internalized as self-stigma (Vogel et al., 2013). Self-stigma has been associated more directly with negative attitudes towards seeking help, so their results may have been different if they had considered self-stigma as well. As such, it would be important to measure self-stigma in addition to perceived public stigma in order to get an accurate and complete idea of how the long-term effects of stigma affect one's perceptions of mental health care.

While they are two distinct job paths, there are certain parallels between being in law enforcement and being in the military. As Wester and colleagues (2010) note, "both institutions

employ techniques designed to break down the recruits' self-identity and rebuild it in the desired image- independence and self-reliance, the restriction of weakness as well as an emphasis on toughness and aggression, in absence of other coping styles" (286). The potential for job-related injuries to occur is also very high for both jobs. As the authors discuss, there are certain job-related consequences associated with being in law enforcement. For instance, even when they are off duty, officers may remain hyper-vigilant and may constantly be on the lookout for dangerous situations. Others may exhibit extreme control over their emotions both at work and when they are at home. Again, both of these characteristics are similar to service members. While these characteristics are adaptive at work, they may not be as adaptive in their personal lives. Wester et al. make an interesting point about the social networks of law enforcement officers in that as an officer's law enforcement identity increases, their relationships with those who are not in law enforcement tend to decrease. This decrease may also lead to a decrease in their social network and support system. The same may be true with service members- as their military identity increases, their relationships with those who are not in the military may decrease, thereby decreasing their support systems.

Wester et al. (2010) note that officers stigmatize counseling not only because of their gender role socialization, but also due to the demands and cultural values associated with their job. Again, this is similar to service members who have been socialized to adhere to certain gender-specific norms, as well as certain military norms that parallel traditional Western masculinity (Danforth & Wester, 2014). Public stigma is especially problematic for law enforcement officers who worry that seeking professional help may have negative consequences for their job. For instance, they may worry that being labelled with a particular diagnosis may affect their current job status, as well as any chance they may have for future promotions. Again,

this is similar to service members who may fear being labelled as unfit to serve or that seeking help may prevent any future promotions.

In their study, Wester et al. (2010) examined the relationships between GRC, anticipated risks and benefits associated with seeking help, and public and self-stigma. There were 178 male police officers who participated in the study. The majority of the sample was Caucasian (79%), and over two thirds of the participants (69%) were married. The authors found that anticipated benefits did not mediate the relationship between GRC and public stigma or self-stigma. It is important to note that the authors did not consider the role of social support and how it may have influenced one's perceptions of stigma towards seeking help. Given the fact that the majority of the sample was married, it would have been interesting to examine how perceived social support may have mediated the relationship between GRC and stigma. Wester et al. also found that anticipated risk fully mediated the relationship between GRC and self-stigma and it partially mediated the relationship between GRC and public stigma. One conclusion that can be drawn from these findings is that anticipated risk is an important factor when determining whether or not to seek professional help, and that risk has more of an influence on help-seeking than benefit does. This is consistent with other research (e.g., Nam et al., 2012), which also demonstrated stronger relationships between risk factors and help-seeking.

Like the civilian population, military members who are experiencing psychological distress often do not seek help for their problems (e.g., Brown, Creel, Engel, Herrell, & Hoge, 2011). Also, similar to the civilian population, the reporting of stigma is one of the greatest contributing factors to not seeking professional help (Skopp et al., 2012). As Skopp and colleagues noted, even though there are many effective, evidence-based treatments available for the mental health disorders that veterans may be experiencing, many do not seek help. In fact,

they noted that service members are much more willing to follow-up on referrals related for physical health, but are much more hesitant to follow-up on referrals related for mental health.

Skopp et al. (2012) discuss how stigma may differ in military health care systems when compared to civilian mental health care systems in that those in the military tend to experience less psychopathology than the general population and they potentially have more to lose by seeking professional psychological help. The authors point out that it is possible veterans or active duty service members would like to seek help for their psychological distress, but do not do so because of both public stigma and self-stigma. For instance, while they may be interested in seeking out mental health service, they may avoid doing so for fear of how they will be perceived by family, friends, or by those with whom they serve. It is also possible that, while they may recognize the importance of seeking professional help, these service members may have internalized certain messages about help-seeking and the implications of doing so (i.e. they are weak or inferior).

While perceived stigma is similar between civilian and military populations, there are also distinct differences in the types of public and self-stigma faced by military members. As such, it is important to have a measure specifically designed to target these factors in service members and veterans. Many of the stigma scales currently in existence did not take the unique experiences of military members into account, which may have led to inaccurately capturing the construct within the population. To correct this, Skopp et al. (2012) created the Military Stigma Scale. Their study sought to develop and validate a scale specifically designed to measure public stigma and self-stigma in service members. There were 1,038 active duty soldiers who participated in this study, and the majority of the sample was male (93.6%).

The authors found that increased perceptions of self-stigma are often associated with higher endorsement of traditional male gender norms. This is consistent with other literature which suggests there is a strong link between gender role conflict and self-stigma (e.g., Wester et al., 2010). Skopp and colleagues (2012) also found that self-stigma was lower in service members who had previously received professional mental health services, or who had known someone who had had a positive experience in therapy. In fact, previous personal positive experiences with psychological help- or knowing someone who has had a positive experience with seeking professional help- may actually decrease the experienced self-stigma (Skopp et al.). At the end of their article, Skopp et al. call for future research to examine the links between stigma, attitudes towards seeking psychological help, and intentions to seek psychological help. This study will begin to examine that link by considering how stigma- along with gender role conflict and support- affects one's attitudes towards seeking psychological help as well as their willingness to do so.

In their seminal study, Hoge and colleagues (2004) sought to examine the relationship between veterans with mental health concerns and barriers to care for those who had not sought help. Their sample consisted of 2,350 soldiers who were surveyed one week prior to deployment to Iraq, 1,962 soldiers from the same battalion who were surveyed after returning home from a six month deployment in Afghanistan, 894 soldiers from another battalion who were surveyed after returning home from an eight month deployment in Iraq, and 815 marines from two different battalions who were surveyed after returning home from a six month deployment in Iraq. The majority of the sample was male and Caucasian.

Hoge et al. (2004) found that of the soldiers and marines who reported some sort of mental health concern, only between 23% and 40% actually sought help after returning home

from deployment. Furthermore, those who screened positively for a mental health disorder were twice as likely to report concerns about stigma and other barriers to seeking help as those who did not screen positively. The authors discussed some of the unique factors that may influence service members' willingness to seek professional help for mental health disorders. In particular, they discuss the effect of public stigma on soldiers and marines, stating that it was significantly higher in those who most needed treatment.

Britt and colleagues (2008) conducted two studies on the effects of perceived stigma and barriers to care on psychological symptoms using two different populations. The first study examined the relationship between perceived stress and depression in college students, and tested whether perceived stigma and barriers to care moderated the relationship between these two variables. Study one consisted of 203 undergraduate students, the majority of which was female (72%). The authors found a significant interaction effect between perceived stress and perceived stigma on the effect of depression. Said another way, for those who perceived more stigma, the relationship between stress and depression was stronger.

The second study examined the relationship between work overload and psychological symptoms in soldiers, and tested whether perceived stigma and barriers to care moderated the relationship between these two variables. There were 3,648 participants in this study, most of whom were male (97%). The authors found that there was a significant interaction effect between perceived barriers to care and work overload on the effect of psychological symptoms. In other words, the relationship between work overload and psychological symptoms was stronger for those who perceived more barriers to care. They did not, however, find that there was a significant interaction between work overload and stigma on the effect of psychological symptoms.

Britt et al. (2008) concluded that both perceived stigma and barriers to care moderate the relationship between life stressors and psychological symptoms, and that these relationships are different for different populations. While their findings shed light on an area that has not really been studied, the purpose of these studies was merely to see whether stigma and barriers to care moderated the relationship between stress and psychological outcomes. They did not take into account how stigma or perceived barriers to care may influence one's attitudes towards seeking help or their willingness to do so. This study highlights how stigma may affect two separate populations who often find themselves in high-stress situations. Their findings highlight the importance of targeting interventions to specific populations since stigma and perceived barriers to care may differ across different groups. The authors state that "college students possess unique demographics that may affect the findings of psychological research" (332). As such, it is important to create studies and interventions that take these unique characteristics into account. College can be an emotionally taxing experience for anyone, but it can be especially difficult for veterans who have already come from emotionally distressing environments. It is, therefore, crucial for researchers and professionals to understand how stigma affects access to care so that interventions can be created to reduce said stigma.

In their study on barriers to mental health care in OEF/OIF veterans, Pietrzak, Johnson, Goldstein, Malley, & Southwick (2009) sought to identify specific risk and protective factors to seeking help for OEF/OIF veterans. Their sample was comprised of 272 participants. The majority of the sample was Caucasian (87%) and they also noted that 85% of the sample had completed some college. Pietrzak et al. found that veterans who met criteria for a psychiatric disorder were more likely to experience higher levels of stigma and to perceive more barriers to seeking help. They also found that negative attitudes and beliefs towards help-seeking and

decreased perceived social support were associated with more perceived stigma and barriers to help-seeking. The items most commonly endorsed on the stigma measure used in this study pertained to self-stigma (i.e. feeling embarrassed or fear of being perceived as weak). This highlights the importance of social support in that those who perceived great social support post-deployment perceived less barriers to seeking mental health care.

The authors discussed several risk factors associated with increased stigma and barriers to care including being younger, being male, and being a racial/ethnic minority. Pietrzak et al. (2009) also noted that specific diagnoses- such as PTSD, depression disorders, anxiety disorders, and substance use disorders- are also risk factors associated with increased stigma. Lastly, they noted that having negative attitudes towards seeking help acts as a risk factor. In addition to discussing potential risk factors associated with barriers to seeking mental health care, Pietrzak et al. also discuss protective factors that may help to decrease stigma and overcome barriers to help-seeking. Specifically, they noted that being married and having social support are protective factors.

While Pietrzak et al. (2009) did discuss some of the demographic information of participants, they did not mention whether the study focused solely on one gender, or whether both genders were included. Furthermore, they did not consider how gender-specific factors may also influence one's perceived stigma or barriers to seeking mental health care. Additionally, the author's finding that being a racial/ethnic minority was a risk factor is somewhat inconsistent when compared to other literature (i.e. Skopp et al., 2012; Britt et al., 2008), which suggests that Caucasian participants tended to report greater stigma. Furthermore, the study did not differentiate between perceived public stigma and perceived self-stigma. While both fall under the bigger umbrella of stigma, they may have different implications in terms of attitudes towards

seeking help, and interventions targeted at reducing stigma will differ based on the type of stigma being addressed.

Wright et al.'s (2009) study sought to examine the relationship between perceptions of stigma and barriers to care and organizational factors. They had 680 participants who were surveyed three months post deployment. They found that there was a negative relationship between organizational factors (unit cohesion and officer leadership) and stigma and barriers to care. More specifically, the authors demonstrated that positive perceptions of organizational factors "succeeded in overriding the relationships between higher symptom levels and higher stigma perceptions regarding treatment-seeking that has been reported in other studies" (Wright et al., 2009; p. 113). This notion of unit cohesion may be similar to social support; the participants may have felt that the other soldiers in their units supported them, so they did not perceive stigma.

As Wright and colleagues (2009) point out, research suggests that those who report the highest levels of mental health problems also tend to report the highest rates of stigma, and this is consistent with both civilian and military samples. Said another way, those who would benefit the most from professional help are often the ones who hold the most negative attitudes towards help-seeking. The authors noted that "some believe that stigma is more pronounced in the military... and endemic to the organizational demands of the military" (110). They posit this might be the case because service members "are expected to function consistently at a high level of readiness and the safety of the unit is dependent on this readiness" (110). Therefore, service members might feel that seeking professional help would lead others to believe that they were not stable enough to handle their jobs. While it is important to reduce stigma and negative attitudes towards seeking help across all populations, it is particularly important to do so with

veterans, who are returning from deployment with increased levels of psychological distress, so that they can get the appropriate help.

Kim, Britt, Klocko, Riviere, & Adler, (2011) noted that approximately 30% of veterans returning from deployment report experiencing some sort of psychological distress; most often tied to PTSD, depression, or anxiety three to six months after returning from deployment. Furthermore, they noted that the rate of veterans experiencing psychological distress tends to increase drastically in the months following returning home. Like others (e.g., Brown et al., 2011; Skopp et al., 2012; Britt et al., 2008), the authors mention that stigma is one of the most common barriers to care. In addition to addressing stigma, however, the authors also mention that other factors- such as negative attitudes towards treatment- may significantly influence one's willingness to seek professional help. In order to test this hypothesis, Kim et al. collected data from a sample of 2,623 active duty soldiers- the majority of whom were male- who had returned from deployment six months ago.

The authors found that soldiers who reporting having some sort of mental health problem were significantly more likely to endorse concerns about seeking treatment than those who did not report having a mental health problem. The authors used a logistic regression in order to determine whether stigma, organizational barriers, or negative attitudes towards treatment predicted the utilization of psychological services. They found that negative attitudes towards treatment were negatively associated with utilization of professional services in that those who held more negative attitudes towards treatment were less likely to seek help. Interestingly, stigma and organizational barriers did not predict utilization of professional services.

Kim et al.'s (2011) study provided support for the idea that there is a strong link between negative attitudes towards seeking help and intentions to seek psychological help. While the

authors found that negative attitudes inversely predicted utilization of services, they noted that it is not clear whether it was the negative attitudes themselves or other factors (i.e. self-reliance, being able to solve problems through other means) that accounted for the soldiers choosing not to seek help. They encourage future research to explore this relationship further. This study will address some of this by measuring support and gender role conflict, which research has also demonstrated negatively influence one's attitudes towards- and willingness to seek- psychological help.

Blais and Renshaw (2013) wanted to better understand the various barriers that impede service members' decisions to seek professional help when experiencing psychological distress. In particular, they focused on self-stigma, marital status, likelihood of future deployment, and previous history with mental health care. Their sample consisted of 165 National Guard/Reserve service members, most of whom were male (92.4%). Like other studies, Blais and Renshaw found that there was a significant relationship between self-stigma and intentions to seek help in that the greater one's self-stigma, the less likely they were to want to seek professional help. The authors also found that marital status significantly impacted one's willingness to seek help. Those who were married reported a greater willingness to seek professional help than those who were not married. The authors state this might be due to the fact that it would be more difficult for service members who are married to hide psychological distress from their partners than it would be for those who are not married. Previous experience with mental health care also had a positive relationship with willingness to seek help in that those who had reported a history of previously seeking help also reported a higher willingness to do so in the present.

Blais and Renshaw (2013) did not find a significant relationship between perceived likelihood of being deployed in the future and intentions to seek help. They note that this might

be due to the fact that only one item was used to measure this idea, but do not provide any ideas as to why future deployment would not be significantly associated with intentions to seek help. This is an unexpected finding that is inconsistent with other research which has demonstrated that public stigma affects one's attitudes towards seeking help (e.g., Britt et al., 2008, Kim et al., 2011, Pietzrak et al., 2009). As such, it is interesting that this sample did not worry about how their unit would have viewed them if they sought help and then were deployed again. Since perceived social support was not measured, it is difficult to say whether this finding was due to perceiving the unit as supportive or whether it was due to other factors.

Gender Role Conflict

Gender role conflict (GRC) stems from gender role socialization in that the strict gender roles men subscribe to prohibit them from acting in a way that is congruent with their thoughts and feelings. This, in turn, creates a significant strain in their lives. Gender role conflict influences all areas of life; O'Neil (1986) believed that it could create problems in four specific domains: the cognitive domain, the affective domain, the behavioral domain, and the unconscious domain (O'Neil et al., 1986). The cognitive domain refers to how an individual thinks about socially prescribed gender roles. The affective domain refers to how an individual feels about said gender roles. The behavior domain refers to how an individual acts or responds with others due to gender roles. Lastly, the unconscious domain refers to how gender roles produce conflicts that are beyond the individual's awareness (O'Neil, 2008). O'Neil (2008) also believed that GRC occurs in specific contexts that are broken down into three categories: intrapersonally, interpersonally, and as experienced by others. Intrapersonal GRC is the internal experiencing of gender role devaluations, restrictions, and violations. Interpersonal GRC occurs when an individual devalues, restricts, or violates someone else in terms of their gender identity.

GRC experienced from others occurs when an individual is devalued, restricted, or violated by someone else.

There are four patterns of gender role conflict: Success/Power/Competition (SPC), Restrictive Emotionality (RE), Restrictive Affectionate Behavior Between Men (RABBM), and Conflict Between Work and Family Relations (CBWFR) (O'Neil, 2008). SPC measures achieving success through power and competition; RE measures the restriction of both expressing one's emotions and the verbal expression of one's emotions; RABBM measures the restriction of one's thoughts or feelings with other men; and CBWFR measures the struggle associated with balancing one's work life with the other aspects of their life. Research has demonstrated that men with higher levels of gender role conflict tend to also experience higher levels of depression, anxiety, substance use, and low self-esteem (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Good, Dell, & Mintz, 1989; & Sharpe & Heppner, 1991). In addition, research has suggested that men with higher levels of GRC tend to have more negative attitudes towards help seeking (e.g., O'Neil, 1986; O'Neil, 2008; Sharpe & Heppner). While all four patterns of GRC has been associated with psychological distress, Restricted Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) seem to be most tied to help-seeking behaviors (e.g., Rochlen & O'Brien, 2002; Danforth et al., under review) perhaps due to the emotional components of both constructs. Furthermore, RE and RABBM have specifically been linked to social support in that social support seems to mediate the relationship between them and help-seeking (Wester et al., 2007; Danforth et al.). As previously mentioned, gender roles define how individuals are supposed to act in society. These gender roles are derived from what society deems as culturally appropriate behaviors, yet they provide "contradictory and unrealistic messages, resulting in considerable internal conflict" (Sharpe &

Heppner; p. 324). Sharpe & Heppner wanted to examine the relationship between male gender role, GRC, and psychological well-being. Specifically, they focused on depression, anxiety, self-esteem, relationship satisfaction, and intimacy. Their sample consisted of 190 male undergraduate students. Their results suggested that there was a positive correlation between high masculinity scores on the PAQ and psychological well-being. They also found that there was a negative correlation between high GRC scores and psychological well-being. PAQ and GRC did not have significant correlation, suggesting that they may measure different constructs. They believe that the GRCS is a better measure in order to get a better understanding of the relationship between negative consequences of masculinity and well-being. Lastly, they found that RE and RABBM were significantly correlated with self-esteem, anxiety, depression, and intimacy.

There are a couple of notable limitations of this study. First, Sharpe and Heppner (1991) did not consider the unique environment of being on a college campus and how it might have affected participants' responses. They discuss how being older may affect some of the variables associated with gender role conflict, but do not consider how younger age may affect these same variables. Additionally, they did not consider how education may impact one's scores on the GRC. As Vogel, Wester, and Larson (2007) note, having some college education and being younger may actually increase positive attitudes towards help-seeking.

As Stillson, O'Neil, and Owen (1991) point out, much of literature that was conducted early on surrounding gender role conflict was done on samples of convenience- male participants who were Caucasian, middle class, and college students. At this time, much less was known about older men's experiences with gender role conflict, as well as the experiences with GRC of men from different cultural backgrounds. Their study sought to address some of the deficits in

the literature by examining how various demographic variables predicted gender role conflict. In particular, they looked at how race/ethnicity, socioeconomic status, employment status, etc. predicted patterns in GRC scores. Their sample was made up of 134 participants between the ages of 22 and 29. The sample was racially/ethnically diverse when compared to other research samples: 47.7% of the sample was Caucasian, 34.1% of the sample was Black, 15.9% of the sample was Latino, and 2.3% of the sample was Asian.

Stillson, O'Neil, and Owen (1991) found that the 13 demographic variables they used did predict different patterns of GRC. More specifically, they found that higher SPC, RE, and CBWFR scores were associated with low vocational strain and high physical strain for Caucasian, Black, and Latino participants. This, as they note, suggests that somatic complaints or physical illness may actually be linked to gender role conflict. Even though they had a small sample, they also note that their study found no differences in GRC patterns across different races/ethnicities when socioeconomic status was not taken into account. When it was, the authors found that Black men from a low SES who were instrumental as well as low on expressiveness, vocational strain, and psychological strain struggled with SPC, but not with the other GRC patterns. The authors state that this "seems logical that lower-class Black men would experience success, power, and competition problems because of their special vulnerability to discrimination on the basis of race and class" (462), but that further research is needed in order to better understand this relationship.

Theodore and Lloyd (2000) wanted to understand how gender role conflict may change over a man's lifespan. They noted that previous research has found that college-age men tend to score significantly higher on SPC than middle-aged men, but that middle-aged men tended to score significantly higher on CBWFR. The authors also noted that previous research had not

found differences between younger and middle-aged men's endorsement of RE and RABBM. The authors sought to extend the literature by focusing on three age groups: younger men (18 to 24 years old), middle-age men (36 to 45 years old, and mature men (60 years or older) as opposed to previous research, which had only focused on younger men and middle-aged men. Their sample consisted of 221 Australian men who were distributed across these three age groups.

Theodore and Lloyd's (2000) study provided further support for previous research, which found that younger men tended to endorse SPC more highly than middle-aged or mature men. They suggest that young men may be striving for success, power, and competition, as opposed to older men who have already accomplished these things. They also indicate that this notion of striving may be more of a developmental characteristic than a product of gender role socialization. While this possibility makes sense, it is inconsistent with previous research (e.g., Wester et al., 2007) which demonstrates no significant relationship between SPC and college students. It is interesting to think about what SPC might look like in service members who have returned to college; while they may be older than typical college-aged men, they are still striving to reach their goals. Perhaps, then, it is not age that affects gender role conflict, but rather where one is in their lives.

Building on previous research, Rochlen and O'Brien (2002) looked at men's attitudes and willingness to see a career counselor. They note that much of the research has focused on attitudes, but not much has considered one's willingness to seek help. Indeed, these two ideas seem to tap into different, yet related areas in that attitudes refers to a beliefs one holds, while willingness/intentions refers more to the behavior. They believed this might be a more attractive option for men who might hold less negative attitudes towards career counseling since the very

idea of traditional therapy, and many of the tenants associated with it (i.e. expressing one's emotions, forming intimate relationships-sometimes with a male counselor) go against masculine gender norms. Their sample consisted of 310 male college students.

Rochlen and O'Brien (2002) found that men who scored higher on the RE and RABBM subscales of the GRCS "attached higher levels of stigma to career counseling than did less traditional men" (18). The authors discuss Good & Wood's (1996) notion of double jeopardy: men who adhere more strictly to traditional masculine gender norms tend to experience more psychological distress than those who do not strictly adhere to these gender norms. They also tend to be the ones who are less likely to seek professional help because of the stigma they associate with help-seeking.

Berger and colleagues (2005) sought to explore the relationship between gender role conflict and help-seeking while considering the impact of age on these variables. This was one of the first studies in the psychology of men and masculinity literature to specifically focus on the impact of age on these variables. The authors indicated that much of the previous research on gender role conflict found that help-seeking tends to decrease as men get older, but that no studies until this point had formally tested the relationship. The authors used a sample of 155 men, ages 18 to 88, who lived in Broward and Palm Beach County, Florida. Men between the ages of 18 and 24 represented 16% of the sample, men between the ages of 70 and 79 represented 23% of the sample, and the rest of the sample was comprised of men between the ages of 25 and 69.

The authors found that there is a relationship between traditional gender role, gender role conflict and attitudes towards seeking psychological help in that those with higher levels of traditional masculine ideology and higher levels of gender role conflict tend to have more

negative attitudes towards seeking professional help. They also found that attitudes towards seeking help are more closely tied to traditional masculine ideology than to gender role conflict, and that only RABBM was significantly correlated with attitudes. They posited that help-seeking may actually be another dimension of masculine ideology, not gender role conflict. They also did not find support for the idea that older men have more negative attitudes towards help-seeking; in fact, they found that older men in the study had more positive attitudes towards seeking professional help than the younger men in the study.

Berger and colleagues (2005) considered how contextual variables may have influenced the outcomes of the study. In particular, they thought about how having a female psychology student may have influenced participants' attitudes towards help-seeking. While this is certainly an important contextual variable to consider, the authors failed to consider any other contextual variables that may have influenced their findings. For instance, they did not consider whether any of the participants were currently experiencing psychological distress, nor did they consider the social support networks that the participants had, both of which have been shown to influence the relationship between gender role conflict and help-seeking (Wester et al., 2007).

In his 2008 article, O'Neil provides an overview of the first 25 years-worth of research on the gender role conflict paradigm. One specific goal of this manuscript was to explore the use of the Gender Role Conflict Scale (GRCS) with diverse populations. O'Neil specifically discusses studies that have used the GRCS with populations of African American men, Latino men, Asian American men, international men, men of different ages, and men of different socioeconomic statuses. He concludes that, while there is not a sufficient amount of studies that explore GRC in diverse populations, there is evidence that "GRC is significantly related to critical psychological variables for men across diversity groups" (O'Neil, 2008; p. 380). While some of the research on

gender role conflict has specifically considered how the unique context of being a college student may impact GRC scores and, ultimately, help-seeking, none of the extant literature has considered how being a service member may impact these variables. Furthermore, a search on Jim O'Neil's webpage dedicated to GRC reveals that only a few dissertations have considered gender role conflict in male service members (<http://jimoneil.uconn.edu/>).

In her dissertation on attitudes towards seeking help in male veterans, Fleming (2012) sought to explore the relationship between gender role conflict, age, psychological distress, and attitudes towards seeking professional help. As she points out, given the fact that that majority of the military is comprised of males, "there is a need to find a way to encourage men to utilize the mental health services that are available to them" (2). Understanding the relationship between gender role conflict and attitudes towards seeking psychological help may help us to gain a better insight into why they do not seek help when experiencing psychological distress which, in turn, will allow us to create effective interventions geared towards increasing positive attitude towards seeking help. Fleming's study was the first study to examine the relationship between gender role conflict and attitudes towards seeking help in male veterans. Her sample consisted of 169 male veterans who had combat experience. There were a few important findings that arose from her study. First, male veterans experience gender role conflict just like their civilian counterparts. Second, she found a significant negative relationship between GRC and attitudes towards seeking help in that as GRC scores increased, attitudes towards seeking help became more negative. Third, there was no statistically significant relationship between age and help-seeking.

While Fleming's (2012) dissertation was one of the first to consider how gender role conflict influences attitudes towards seeking help in a military population, there are some limitations to her study. First, she did not include a measure designed to measure one's attitudes

towards seeking help; she merely used a single question in her demographics questionnaire asking participants whether they would be willing to seek professional help for mental health-related issues. It is possible that this one question did not adequately capture the concept of attitudes towards seeking help. Second, even though RABBM has been linked more strongly to attitudes towards seeking help, Fleming removed it from her study. When she was gathering data for her dissertation, the “Don’t Ask, Don’t Tell” policy was still in effect in the military. Since RABBM specifically asks questions about affectionate behaviors between men, participants did not feel comfortable answering the questions on this subscale. Since that policy is no longer in effect, this researcher plans on including RABBM in order to see whether there is a significant relationship between it and help-seeking. Fleming also did not consider the role of stigma in the lives of the male veterans, and how it might impact their attitudes towards seeking help.

Research has consistently demonstrated that there is a negative relationship between both public and self-stigma and attitudes towards seeking help. As such, this researcher plans on including a measure that looks at both forms of stigma in order to gain a better understanding of how gender role conflict and stigma influence help-seeking.

With over 21 million veterans currently living in the United States (Danforth & Wester, 2014), it is important that researchers understand how gender role conflict may impact their willingness to seek help so that interventions geared towards increasing willingness can be tailored specifically to this population.

Contextual Factors of Gender Role Conflict

Throughout decades of research in the psychology of men and masculinity, gender role conflict has often been seen as a socially constructed, inherent trait in men. GRC has been used as a predictor variable, thereby suggesting that it can be mediated or moderated by contextual

variables, which then lead to various outcomes. There is a new paradigm shift occurring in the area of men and masculinity, though, because researchers are beginning to realize that GRC may not be a trait, but may in fact be a state (Jones & Heesacker, 2012). The term, microcontext, can help clinicians understand how masculinity, and gender role conflict in particular, may influence one's behaviors and how said behaviors are a result of the particular environment. Jones and Heesacker define microcontext as a "set of cues, norms, and outcome expectations associated with a given temporally limited environment" (p. 295). They believe that microcontexts are situation-specific in that different situations may elicit different responses. For instance, it is socially appropriate for male athletes to slap each other on their butts while playing a sport, but such behavior would not be appropriate in other contexts. According to Jones and Heesacker, current research believes that gendered attitudes and behavioral responses tend to accumulate over time, thereby strengthening the gender role conflict. Often times, researchers do not take into account how the situation one is in may influence the response. The notion of microcontexts suggests that different situations call for different attitudes and behavioral responses.

In their study, Jones and Heesacker (2012) tested the notion that gender role conflict could be influenced by contextual factors. Their study consisted of 158 participants from a southeastern university. In order to create different microcontexts, the authors primed participants by showing them comedic video clips. They found that Gender Role Conflict Scale (GRCS) scores were lower for participants in the priming condition when compared to the control group. More specifically, they noticed that the GRCS scores changed significantly for those who were in the priming condition (that watched a video for 4 minutes) when compared to the control group. This provides support for the idea that gender role conflict is, indeed, context-specific. Jones and Heesacker make an interesting point that the GRCS itself may serve as a

microcontext in that it may prime participants by focusing on traditional masculine gender roles. This researcher will try to test this idea by placing the GRCS at different points in the study. Therefore, if it does, in fact, serve as a prime, there will be different scores depending on where in the survey it falls.

In their seminal article on masculinity and help-seeking, Addis & Mahalik (2003) make the claim that “*gender* is a verb rather than a noun” (9). In other words, gender is something people do and it is something that is enacted in different situations. This implies that it may not be an inherent trait as it has been treated in the literature for the last 30 years (O’Neil 2008). Again, this gives way to the idea that gender is something that is done, not something that is possessed. The definition of GRC itself states that it is a psychological *state* that produces negative outcomes in the lives of men and others. It is important to understand the nature of GRC so that we may better understand its relationship to help-seeking. Addis and Mahalik state “the difficulty in accounting for within-person and across-situation variability arises because masculinity, though assumed to be social in origin, is still treated as a stable, internal, traitlike construct” (8). This gets to the point that GRC may, in fact, be dependent on the situation the individual is in, thereby suggesting that these behaviors occur within particular states, and are not deeply ingrained traits. The authors go on to say that in order to we must better understand the within-person across-situation variables that influence a person’s decisions to seek help. The authors also suggest that researchers look at person-environments that may also affect one’s attitudes towards help-seeking. While much of the literature on help-seeking has used samples of college students, few studies have considered how this environment- this microcontext- might affect one’s attitudes towards seeking help.

In their study, Groeschel, Wester, and Sedivy (2010) sought to examine the relationship between GRC, use of alcohol, and attitudes towards seeking help in male college students. This is one of the only studies that used gender role conflict as a mediating variable rather than a predictor variable. Their sample was comprised of 399 male college students, the majority of whom were Caucasian (89%), seniors (35.1%), and single (91.5%). Initially, the authors had considered gender role conflict the predictor and negative alcohol-related consequences the mediator, but ended up switching their model so that negative alcohol-related consequences was the mediator and GRC was the mediator. They did so because, as they state, “GRC can be considered primarily representative of the negative consequences associated with tensions between socialized male behaviors and the demands of a situation” (133). It appeared that alcohol-related consequences independently influenced attitudes towards help-seeking, so it would make sense that this would be the predictor variable. Placing gender role conflict as a mediator, then, helped to strengthen the relationship between alcohol-related consequences and attitudes towards seeking help. They found that their model was statistically significant; there was a positive relationship between negative alcohol-related consequences and GRC, a negative relationship between GRC and help-seeking, and a negative relationship between negative alcohol-related consequences and help-seeking. This study provides support for the use of gender role conflict as a mediating variable instead of a predictor variable.

Social Support

Much of the extant literature on help-seeking has focused on barriers to seeking help (e.g., public and self-stigma and gender role conflict), but it is also important to consider potential factors that may positively influence one’s willingness to seek professional help. One such factor that has emerged in the literature is social support. Social support can be seen as a

protective factor for potential mental health outcomes which acts as a buffer between negative life events and psychological distress. Research consistently demonstrates that social support is not a fixed trait in people, but rather it can be seen as a state. It evolves based on individual qualities of the person (i.e. their well-being), as well as based on their environment. Social support appears to be more stable from family members, but social support from peers varies a little bit more depending on “the continuing renegotiation of peer relationships during late adolescence” (Whiteman et al., 2013; p. 266).

According to Jacobson (1986), social support is a “complex phenomenon” (252), which is comprised of different types, aspects, and categories of social support. These different types of support include emotional support, cognitive support, and materials support (e.g., Jacobson, 1986; Hefner & Eisenberg, 2009). Emotional support includes “behavior that fosters feelings of comfort and leads an individual to believe that he or she is admired, respected, and loved, and that others are available to provide caring and security” (Jacobson; p. 252). Cognitive support refers to information, advice, or knowledge received from others that helps an individual make sense of their world. Lastly, materials support includes “good and services that help to solve practical problems” (Jacobson; p. 252). There are also certain aspects of social support that one must be mindful of. The structural aspect refers to the number of relationships one has, while the functional aspect refers to the perceived quality of said relationships (Hefner & Eisenberg).

Whiteman et al. (2013) believed that social support could be simplified into two categories: psychological support and non-psychological support. They focus on psychological support, which can be looked at as a composition of cognition and emotional support. Emotional support, in particular, has been associated with better physical health and mental health. Research has demonstrated that emotional support can act as a buffer between stressful life

events and psychological outcomes. The authors note that measuring emotional support would be especially important in service members and veterans who have “unique mental (e.g., psychological distress and PTSD) and behavioral (e.g., alcohol abuse) health outcomes typically associated with service and deployment” (267). With regards to service members and veterans on college campuses, Whiteman et al. believed that there was less perceived emotional support and informational support from their peers.

Whiteman et al. (2013) discuss the differences that have emerged in social support research. With regards to gender, research demonstrates that “women are more likely than men to seek, provide, and receive social support (especially emotional support)” (267). Furthermore, they note that those who are married tend to perceive more social support than those who are not. Lastly, they note that as individuals get older, their social support networks decrease in size, but that does not mean that the quality of said network changes. As Wester and colleagues (2007) discuss, social support research has often focused on the relationship between stressful life events, social support, and psychological outcomes (e.g., depression, anxiety, and PTSD). More specifically, research demonstrates that social support often mediates the relationship between stressful life events and psychological outcomes and acts as a buffer against negative psychological outcomes. Research in the area of men and masculinity has found mixed results. Some studies (e.g., Osborne, 2004) demonstrated that social support partially mediates the relationship between GRC and help-seeking, while others have found negative correlations between GRC and social support.

Not only is social support an important component of one’s well-being, but it may also be tied to influencing others to seek help. When experiencing psychological distress, “researchers have suggested that those closest to the individual play an influential role in whether or not an

individual seeks mental health services when experiencing distressing symptoms” (Vogel et al., 2007; p. 234). Vogel and colleagues discuss a study done by Horwitz (1977), which found that people tended to talk to at least four people in their social network about their psychological distress before they decided to seek professional help. This, again, lends itself to the notion that help-seeking is often seen as a last resort. Similarly, they discuss a study conducted by Dew et al. (1991), which found that those who decided to seek professional help tended to have someone from their social network who recommended that they seek professional help, whereas those who decided not to seek professional help did not receive that recommendation.

Vogel et al. (2007) note that “one of the primary determinants of help-seeking intentions is one’s attitude toward the therapy process” (234). Said attitudes are “general opinions or feelings about therapy and are formed through an evaluation and weighing of the anticipated outcomes (i.e., the benefits and risks) and social norms associated with seeking mental health services” (234). Potential benefits of seeking professional help include reduction in psychological distress and an increased sense of support. Potential risks of seeking professional help include “fear of violating gender role expectations, embarrassment over sharing problems with strangers, and vulnerabilities resulting from self-disclosure” (234). There is not a lot of research available that looks at the effects of one’s social network on their decisions to seek professional help. As previously stated, research has consistently shown that men seek help less frequently than women for an array of issues. Vogel et al. suggested that part of the reason why may be due to their social networks. More specifically, it’s possible that “people are less likely to support men seeking mental health services than women, particularly for issues that go against the prescribed roles for men (i.e., need to be strong and withhold certain emotions” (235).

Vogel and Wei (2005) note that in order for psychologists and researchers to be able to reach out those who are in need of services, it is essential that they first have an understanding of the specific individual factors that may affect an individual's decisions to seek help. This is especially pertinent since less than one-third of people experiencing psychological distress seek professional help for their problems. Research has demonstrated that those with weaker perceived social support networks tend to be more likely to seek help. Vogel and Wei state this might be the case because the lack of social support may lead to more psychological distress, which predicts help-seeking. While this idea makes sense, it is inconsistent with other research that has found that those with weaker social support networks are less likely to seek help (Vogel et al., 2007). While one's need for professional help may increase, does it necessarily follow that their willingness to seek professional help will also increase? For men, this may not be the case.

Vogel and Wei (2005) sought to expand the current understanding of help-seeking and the role of social support by considering how attachment anxiety and avoidance affected perceived social support and psychological distress, and how all of these variables affected one's intentions to seek help. There were 355 participants in their study, all of whom were undergraduate students. The majority of the sample was female (67%), first year students (65%), and Caucasian (85%). The authors found that those with attachment avoidance and anxiety perceived less social support, and this relationship was negatively associated with psychological distress. Furthermore, they found that there was a positive relationship between psychological distress and intentions to seek help. Taken together, these findings suggest that the perception of less social support led to greater psychological distress which, in turn, led to greater intentions to seek professional help. This is an interesting finding given that previous research has talked

about the “service gap” (Nam et al., 2012) that exists between those who need psychological help and their actual intentions to seek said help.

Wester et al. (2007) sought to better understand the relationship between GRC, social support, and psychological distress for men. Their sample was comprised of 396 male undergraduate students, the majority of whom were first year students ($n = 194$) and Caucasian ($n = 353$). The authors found that social support mediated the relationship between RE and RABBM and psychological distress, but that it did not mediate the relationship between SPC and CBWFR and psychological distress. The authors note that “men who scored highly on RE and RABBM subscales of GRC likely had poorer levels of social support accounting for their increased psychological distress” (221). They go on to state that “many traditionally socialized men avoid activities that may seem feminine (such as, perhaps, seeking social support) to enhance their masculine identity” (221). With regards to SPC, the authors note that a certain level of SPC may actually be adaptive in college settings.

The authors also found there was a significant relationship between CBWFR and psychological distress, but this relationship was not mediated by social support. The authors suggest that when men experience tensions between work and family, they withdraw from their relationships and end up putting more energy into their work, which then decreases social support even more since they are not available for social interactions. As such, social support does not have the opportunity to mediate the relationship between CBWFR and psychological distress. Indeed, “increased adherence to the male gender role produces more psychological distress and increased isolation, which in turn leads to more isolation in pursuit of the male gender role and increased psychological distress” (Wester et al., 2007; p. 222). Wester et al. also found that social support moderated the relationship between RABBM and psychological

distress. Overall, the authors state their findings provide support for the idea that social support can reduce certain effects of GRC on psychological distress.

Vogel and colleagues (2007) sought to expand the extant literature by examining the relationships between one's social networks and help-seeking. Their study was three-fold: 1) they sought to understand the effect that one's social network had on their perceived social norms and anticipated outcomes of seeking help; 2) they sought to understand the relationship between one's social network and their attitudes and intentions towards seeking help; and 3) they sought to understand any differences that may exist for men and women with regards to the relationship between one's social network and attitudes/intentions to seek help. This was done in two studies: the first study had 780 college students, 55% of whom were women, 47% of whom were first year college students, and 91% of whom were Caucasian. The second study had a separate sample of 746 participants, 52% of whom were female, 59% of whom were first year college students, and 91% of whom were Caucasian.

Overall results from Vogel et al.'s (2007) study suggest that for the majority of the time (74% to 78%), those who sought help were encouraged to do so. Furthermore, the majority of those who sought help (92% to 95%) knew someone else who had sought professional help. The authors conclude that "those close to an individual may be related to the decision to seek mental health services, as most people in treatment were specifically prompted to seek help by someone close to them and knew someone who had sought treatment" (241). Additionally, across both studies, those who knew someone else who had sought help tended to have more positive expectations about therapy and about how they thought their social network would react to them seeking help. In Study 2, the authors found that those who knew someone else who had sought help also tended to have more positive attitudes towards help-seeking, as well as greater

intentions to seek help. As the authors state, “attitude toward mental health services is at least partially transmitted by family and friends who therefore play a role in whether an individual decides to seek help” (241).

Vogel et al. (2007) did find a difference in gender in that women were both more likely to have known someone who had previously sought help and were more likely to be recommended to seek help. Again, this is consistent with the authors’ previous claim that people may not feel as comfortable recommending therapy to men when society teaches them that they should solve their own problems. An interesting finding was that 47% of participants reported that their mothers recommended they seek professional help, while only 5% of participants’ fathers suggested that they seek help. Again, “silence from fathers about seeking help may be further reinforcing gender stereotypes of help seeking” (242).

Hefner and Eisenberg (2009) state that research on social support has consistently found a positive relationship between it and one’s overall psychological well-being. The authors report that over half of the emerging adults currently living in the United States attend some sort of post-secondary education. They go on to say that this time of emerging adulthood is often marked by a greater sense of freedom, as well as psychologically distressing factors (i.e. increased inter-personal conflict and social isolation). Changes in inter-personal relationships may also have effects on one’s perceptions of social support. Since this is such a unique time in students’ lives, the authors wanted to examine the relationships between perceived social support and mental health outcomes in college students. Their study was threefold: 1) they wanted to know, in general, about perceived social support in a college setting, as well as across demographic variables; 2) they wanted to better understand the relationship between social support and psychological outcomes; and 3) they wanted to know which types of social support

produce the strongest relationships with psychological outcomes. Their sample consisted of 2,843 randomly sampled undergraduate and graduate students from the *Healthy Minds Study*.

Hefner and Eisenberg (2009) found that there were demographic differences in social support. More specifically, those at greater risk for social isolation included racial/ethnic minority students, international students, and students from a lower socioeconomic status. Additionally, male students and those not living with a significant other reported a lower quality support. The authors also found that there was a significant negative relationship between social support and mental health in that those with higher perceived social support tended to experience lower rates of a variety of psychological issues, including depression, anxiety, suicidal ideations, and eating disorders. On a related note, they found that both structural support and functional support were associated with mental health, but that there was a stronger relationship between functional support and psychological well-being.

In their study on gender role conflict, social support, and help-seeking in college students, Danforth et al. (under review) begin to make the links between these variables. They state that “feeling less social support may be an important element in fully explaining the linkage between GRC and help-seeking behavior” (2). The purpose of their study was to begin testing these relationships in order to determine the relationships between these variables. The authors only used the Restricted Emotionality (RE) and Restricted Affectionate Behavior Between Men (RABBM) subscales of the GRCS; their decision to do so was based off of previous research (Wester et al., 2007), which found that social support only mediated the relationship between RE and RABBM and help-seeking. Their sample consisted of 336 male undergraduate college students, the majority of whom were first year students (62%) and Caucasian (79%). Danforth et al. found that perceived social support fully mediated the relationship between RABBM and

willingness to seek help. This finding suggests that when men feel as if they are supported by others and that they would be supported in their decision to seek professional help, they are more likely to do so regardless of gender role conflict. There was an interesting finding that emerged from the data in that RE did not predict willingness to seek help. The authors believe this may be due to the fact that counseling is “less about the simple expression of emotions and more about the expression of those emotions to another person” (9).

Whiteman and colleagues (2013) discussed the drastic increase in the number of military personnel attending college, but go on to say that there is a lack of research on service members’ and veterans’ adjustment to higher education, as well as the unique needs they require to adjust successfully. In addition to the aforementioned problems that service members on campus often face, additional issues they may experience include personal issues (i.e. forming relationships with other students) to educational issues (i.e. support from the university itself). Whiteman et al. note that qualitative research consistently demonstrates that service members’ and veterans’ perceived social support is an essential component of helping them to successfully adjust to college. The authors note, however, that there are not many quantitative studies that focus on social support and service members/veterans. Indeed, a review of the literature reveals very few quantitative studies that have focused on college adjustment, social support, and military service members; most tend to focus on mental health concerns, such as PTSD, alcohol use, and suicidal ideation.

Social support not only influences service members’ adjustment to college, but it can also affect their academic progression. Indeed, Whiteman and colleagues (2013) state that not being able to connect with peers could not only affect service members’ and veterans’ adjustment to college, but their academic progression as well because ““integration into the social and

intellectual fabric of the institution' is one of the most important predictors of student persistence" (266). Research has demonstrated that social support predicts retention and higher GPA. Social support has not only been linked with physical health outcomes, but it has also been linked with better overall mental health while in college and beyond. Those without social support are more likely to experience symptoms of depression and anxiety. For veterans, those who perceived more social support reported less symptoms of PTSD.

In their study, Whiteman et al. (2013) examined perceived emotional support received from peers for both service members/veterans and civilian students. This study was unique in that it was a longitudinal examination of social support over three consecutive semesters in order to track changes in adjustment and academic outcomes. Their sample consisted of 380 participants, 199 of whom were service members or veterans and 181 of whom were civilian students. The majority of the service member/veteran sample was male ($n = 154$), while the majority of the civilian sample was female ($n = 100$). The majority of both samples were Caucasian (92% of the veteran sample, 90% of the civilian sample). The service member/veteran sample was slightly older ($M = 29.41$) than the civilian sample ($M = 23.67$), and there was a higher percentage of married service members/veterans (34%) than civilian students (8%).

Whiteman et al. (2013) found that, when compared with civilian students, service members/veterans tended to report less emotional support at Time 1. Over time, however, both civilian students' and service members'/veterans' perceptions of peer emotional support increased similarly. Even though they increased similarly over time, service members'/veterans' perceptions of emotional support was not equal to the support perceived by civilian students at Time 3 since they did not start off at the same point. The authors also found that perceived emotional support was a protective factor for students as it was related to both positive mental

health outcomes and positive academic outcomes. The authors also found that “emotional support from peers was associated with little change in psychological distress among student service members/veterans” (274). The authors state that “emotional support from peers may be insufficient to buffer against the psychological problems prevalent among student service members/veterans” (274).

While this study was the first to provide information on the longitudinal effects of social support for service members, there were a couple of notable limitations. At the beginning of the article, the authors note that previous research has demonstrated that there are gendered differences in social support in that women are more likely to seek, provide, or receive social support. That being said, it would have been helpful if they would have considered- or at the very least controlled for- differences in perceived social support for male and female participants in their study. Similarly, Whiteman and colleagues (2013) did not consider how other factors- such as public or self-stigma- may have been impacting participants’ psychological distress. Therefore, they cannot conclude that emotional support may not be a sufficient buffer when they did not consider the effects of these other factors.

While their study did not focus on college students, Sayer and colleagues (2009) sought to better understand barriers and facilitators that influenced one’s willingness to engage in PTSD treatment. The authors conducted a qualitative study with 44 veterans, half of whom were Vietnam veterans and half of whom were OEF/OIF veterans. The majority of the sample was male (68%) and Caucasian (97%). Less than half of the sample (45%) was married and half of the sample (50%) had completed some college. Additionally, half of the sample was already in treatment for PTSD, while the other half was not yet in treatment.

Sayer et al. (2009) found that 66% of their sample met criteria for moderate to severe depression, 52% of the sample participated in hazardous drinking, and- depending on the cutoff score used for diagnosing PTSD- approximately 66% to 91% met criteria for PTSD. The authors found that negative beliefs about treatment, valuing self-reliance, and access to care were some of the prominent barriers that prevented participants from wanting to seek help. With regards to facilitators, one that was frequently mentioned was social support. Those in the participants' social networks often helped and encouraged them to seek help, and helped them overcome some of the other barriers to seeking help, such as negative beliefs about treatment and access to care. Two of the most influential sources of influence were veterans' spouses and other veterans. For instance, many of the OEF/OIF veterans were often encouraged to seek PTSD treatment from Vietnam veterans.

Summary

This literature review highlights several factors that influence men's attitudes towards seeking help, as well as their intentions to do so. Past research suggests that stigma influences help-seeking attitudes and intentions in civilians (i.e., Vogel et al., 2013; Wester et al., 2010). Similarly, research also suggests that social support mediates the relationship between gender role conflict and help-seeking in civilians (e.g., Wester et al., 2007; Danforth et al., 2014). There is a significant gap in the literature with regards to how gender role conflict affects help-seeking in male service members. No studies were found that utilized the entire GRCS, ATSPPH scale, or the ISCI. Furthermore, no studies were found that examined how stigma and social support mediate the relationship between gender role conflict and help-seeking in male service members.

Previous research has demonstrated that both civilian men and male service members seek help at lower rates than their female counterparts (e.g., Addis & Mahalik, 2003; Mansfield

et al., 2005). Furthermore, research demonstrates that there is a significant need for psychological services for service members, but that they are likely reluctant to seek these services (e.g., Danforth & Wester, 2014; Hoge et al., 2004; Skopp et al., 2012; Whiteman et al., 2013). It is important to understand how specific factors may act as barriers or facilitators to seeking help in male service members so that mental health providers can create interventions tailored to helping service members overcome their reluctance towards seeking psychological help.

Chapter III

METHODS

In order to increase positive attitudes towards seeking psychological help and willingness to seek help, one must first understand the factors that influence these attitudes. The goal of this study was to determine whether gender role conflict, stigma, and social support predicted positive attitudes towards seeking psychological help in male service members on a college campus. More specifically, this study tested a model in which social support and stigma mediated the relationship between gender role conflict and help-seeking.

Primary Hypotheses:

- Stigma will partially mediate the relationship between gender role conflict and help-seeking in male service member college students in that the higher the gender role conflict score and the stigma score, the less willing participants will be to seek help.
- Social support will partially mediate the relationship between gender role conflict and help-seeking in male service member college students in that the higher the gender role conflict score, the less willing participants will be to seek help.

Secondary Hypothesis:

- The Gender Role Conflict Scale will produce different scores in participants based on where in the questionnaire it is located.

Participants

A total of 193 participants completed the entire survey either online or in person. The majority of participants ($n = 168$) completed the survey online. There do not appear to be any differences in responses due to whether the survey was completed online or in person. All participants were male, current students, and identified as military service members. Most of the

participants self-identified as Caucasian/European-American (87%, n = 168), with the remainder identifying as African American (4.1%, n = 8), Other (3.1%, n = 6), Hispanic or Latino (2.6%, n = 5), American Indian/Alaska Native (1.6%, n = 3) Asian American (1%, n = 2), and Native Hawaiian or other Pacific Islander (0.5%, n = 1). Over half of the sample (58%) were between the ages of 18 and 29. The rest of the sample were between the ages of 30 and 56 years old.

All five military branches were represented in this study: Army, n = 97; Navy, n = 14; Air Force, n = 23; Marine, n = 58; and Coast Guard, n = 1. 74.6% of participants (n = 144) reported they were Active Service; 17.1% (n = 33) reported they were Reserves; 4.1% (n = 8) reported they were National guard; 3.6% (n = 7) reported they were ROTC; and 1 participant did not respond to this question. 95.3% (n = 182) of the sample were enlisted service members while 5.7% (n = 11) of the sample were officers.

Measures

Demographic questionnaire. Items included race/ethnicity, current age, age they entered the military, and student status. This questionnaire also asked questions about military service including in which branch of the military participants served, years of service, whether or not they were ever deployed (and if so, how many times), how long they have been home for, and whether or not they had received any sort of mental health treatment since returning home.

Attitudes Towards Seeking Professional Psychological Help Scale Short Form (ATSPPH; Fischer & Farina, 1995). The ATSPPHS Short Form is a ten-item questionnaire that assesses one's attitudes towards seeking help. Items are scored on a 4-point Likert scale ranging from 0 (strongly disagree) to 3 (strongly agree), with five items reverse-scored. Higher scores indicate more positive attitudes towards help seeking. Items include "If I believed I was having a mental breakdown, my first inclination would be to get professional attention" and "The idea of talking

about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts”.

The internal reliability for the ATSPPH Short Form Scale is .84 and the test-retest reliability with a 1-month period between tests is .80 (Fischer & Farina, 1995).

Revised ATSPPHS: After conducting a confirmatory factor analysis, items 2, 4, 8, 9, and 10 were used from the Attitudes Towards Seeking Professional Psychological Help scale. These items created the composite variable for Attitudes. The Cronbach’s Alpha for the five items used was 0.88.

Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). The ISCI consists of 17 items designed to assess how likely one is to seek counseling for the problems listed. Problems include depression, anxiety, relationship issues, etc. Items are scored on a 4-point Likert scale ranging from 1 (very unlikely) to 4 (very likely). Higher scores indicate more willingness to seek counseling. There are three subscales in the measure: Psychological and Interpersonal Concerns (Internal consistency of .90), Academic Concerns (Internal Consistency of .71), and Drug Concerns (Internal Consistency of .86).

Due to the poor factor loadings during the confirmatory factor analysis, this measure was removed from the study.

Gender Role Conflict Scale- Short form (GRCS-16; Wester, Vogel, O’Neil, & Danforth, 2010).

The GRCS-16 is a 16-item measure that looks at men’s thoughts and feelings regarding gender role behaviors. Items are scaled on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly agree). Overall scores are calculated by adding the individual item responses and dividing by 16. There are four subscales in the GRCS-16: success, power and competition; restrictive emotionality; restrictive affectionate behavior between men; and conflicts between work and family relationships. Subscale scores are calculated by adding the items in each

subscale and then dividing by the number of items in that particular subscale. When using Cronbach's alpha, the internal consistency for the GRCS-16 ranged from .75 to .86.

Revised GRCS: After conducting a confirmatory factor analysis, only the Restrictive Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) subscales were used. These eight items created the composite variable for Gender Role. The Cronbach's Alpha of the eight items making up the RE and RABBM subscales was 0.85.

Military Stigma Scale (MSS; Skopp et al., 2012). The MSS consists of 26 items, and is designed to measure mental health stigma in military service members. Items are scaled on a 4-point Likert scale, ranging from 1 (Definitely Disagree) to 4 (Definitely Agree). Items include "People I respect would think less of me if they knew I had mental health problems" and "If I went to a therapist, I would be less satisfied with myself". There are two subscales in the MSS: public stigma and self-stigma. Subscale scores are calculated by adding the items in each subscale. The internal consistency score for the Public Stigma subscale is .95 and the internal consistency score for the Self-stigma subscale is .87. This researcher gained permission to use the Military Stigma Scale for data collection from Dr. Nancy Skopp via electronic communication. Dr. Skopp responded with an email, which contained the MSS and how to score it.

Revised MSS: After conducting a confirmatory factor analysis, only items 7, 13, 15, 16, 18, and 22 were used in order to measure Self-Stigma. These six items created the composite variable for self-stigma. The Cronbach's Alpha for the six items used was 0.73.

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). The MSPSS is designed to measure perceived emotional support from family, friends, and significant others. The scale is comprised of 12 items, which are measured on a 7-point Likert scale where 1 is Very Strongly Disagree and 7 is Very Strongly Agree. Items include "There is a special person

who is around when I am in need” and “I get the emotional help and support I need from my family”. The total score is calculated by adding up all of the items; the higher the total score, the more emotional support one perceives. The overall internal consistency for the MSPSS is .88. In this study, the Cronbach’s Alpha for this measure was 0.96.

Structural support: This researcher was unable to find a published measure assessing the structural aspect of social support, or the quantity of relationships an individual has. Therefore, to assess this aspect of social support, Hefner & Eisenberg’s (2009) methods for assessing structural support will be replicated. The authors used two questions from the *Berkley Graduate Student Mental Health Survey* regarding how often participants were in contact with family and friends. The first item asks, “In the past 12 months, how often did you talk to a family member (including a quick phone call or email)?” Responses range from “at least once a day,” “at least once a week,” “at least once a month,” “less than once a month,” to “not at all.” The second item asks, “In the past 12 months, how often did you do things with any close friends (even a quick phone call or encounter)?” Again, responses range from “at least once a day,” “at least once a week,” “at least once a month,” “less than once a month,” to “not at all.”

Due to the poor factor loadings during the confirmatory factor analysis, this measure was removed from the study.

Procedures

Participants were primarily recruited online, but some were recruited in person as well. Participants were contacted via an e-mail listserv through the Military and Veteran Resource Center (MAVRC) at UW-Milwaukee asking for their participation in the study. The snowball effect was also used for electronic data collection. This writer passed the survey on to friends who then distributed it to any service members who fit the necessary criteria. This writer also

collected data in person by visiting the Military and Veteran Resource Center and distributing paper copies of the survey. In-person data collection also occurred through community organizations specifically targeted at working with male veterans.

Those who agreed to partake in the study were first informed that participation was voluntary and that identifying information would remain confidential and would only be available to the primary and secondary investigators. It was reiterated several times throughout the email, the in-person conversations, and the informed consent that responses would remain anonymous. Those who chose to participate online gave consent by clicking “continue” and were then taken to the survey. Those who chose to participate in person signed the informed consent sheet, which was kept separate from their responses.

After agreeing to partake in the study, participants were asked to complete a survey, and were told it would take approximately 20 minutes to complete. The email that was distributed and the link that was posted online provided a link to the survey site, which contained the informed consent, the demographic questionnaire, and the self-report instruments including: (a) The Gender Role Conflict Scale-Short Form (GRCS-16; Wester, Vogel, O’Neil, & Danforth, 2010); (b) The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988); (c) Two questions from the Berkley Graduate Student Mental Health Survey regarding how often participants were in contact with family and friends; (d) The Military Stigma Scale (MSS; Skopp et al., 2012); (e) The Attitudes Towards Seeking Professional Psychological Help Scale Short Form (ATSPPH; Fischer & Farina, 1995); and (f) The Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). Three versions of the survey were created: the first version had the Gender Role Conflict Scale as the first measure, the second version had the

GRCS in the middle of the survey as the fourth measure, and the third version had it as the last measure. Participants were randomly assigned to one of the three conditions.

Upon completion of the study, participants were compensated for their time. They had the option of choosing to keep the \$2 for themselves, donate the \$2 to the UW-Milwaukee Military and Veteran Resource Center, or donate the \$2 to the Wounded Warrior Project. For those completing the survey online, they were asked to provide their PayPal email address so this writer could send them the \$2 electronically.

Research Design

This study hypothesized that stigma would partially mediate the relationship between gender role conflict and help-seeking. Additionally, it hypothesized that social support would partially mediate the relationship between gender role conflict and help-seeking. A mediator is defined as “a variable that explains the relation between a predictor and an outcome” (Frazier, Tix, & Barron, 2004; p. 116). Said another way, a mediator is “the mechanism through which a predictor influences an outcome variable” (116). In order for mediation to occur, three conditions must be met: 1) the path between the predictor variable and the mediating variable (path a) must be significant; 2) the path between the mediating variable and the outcome variable (path b) must be significant; and 3) the relationship between the predictor variable and the outcome variable (path c) must be significant (Baron & Kenny, 1986). If all three of these conditions are met, mediation is said to occur.

Structural Equation Modeling (SEM) was used in order to test the relations between the variables of interest. SEM is comprised of two major components: the measurement model and the structural model. The measurement model allows us to test the relations between observed variables and latent variables (Deshon, R.P., 1997). Latent variables are the variables of interest

that are not directly measured (i.e. constructs). Observed variables, on the other hand, are the variables that are being directly measured. Latent variables are comprised of observed variables (Hoyle, 1995). For example, Gender Role Conflict is a latent variable in this study, while its four subscales- SPC, RE, RABBM, and CBWFR- are the observed variables. In order to construct and test the fit of the measurement model, confirmatory factor analysis (CFA) is used. After a measurement model is tested for goodness of fit, the model may need to be modified. More specifically, the relations between variables may need to be re-specified. This modified version of the model is called the structural model, and it is used in order to test the relations between the latent variables (Deshon, R.P.).

There are five steps in Structural Equation Modeling: specification, identification, estimation, testing, and modification (e.g., Hoyle, 1995; Weston & Gore, 2007). The first step in SEM is model specification, which is where the researcher must determine all of the relationships and parameters they are interested in examining (See Fig. 1 for hypothesized model). Figure 1 depicts the hypothesized model for this study. There are three direct effects that will be tested, as well as two indirect effects. A direct effect suggests that the predictor variable has a causal relationship with the outcome variable (Rex, 2011). In Figure 1, paths b, c, and e are the proposed direct paths between the respective predictor variables and the outcome variable. An indirect effect suggests that the predictor variable causes the mediating variable, which then causes the outcome variable (Hoyle). In Figure 1, paths A' and B' are the proposed indirect paths.

The second step is model identification, which looks at “whether a single, unique value for each and every free parameter can be obtained from the observed data” (Hoyle, 1995; p. 4). Models can be under-identified, just identified, or over-identified. A model is considered under-

identified if a single, unique value cannot be obtained for each free parameter. Just identified models are comprised of values that are obtained “through one and only one manipulation of the observed data” (Hoyle, 1995; p. 4). If a model is over-identified, this suggests that there are multiple values that can be obtained for each free parameter. The purpose of model estimation, the third step in SEM, is to find estimates of the free parameters from the collected data. This will be done through maximum likelihood estimation (MLE) (Rex, 2011). Maximum likelihood “describes the statistical principle that underlies the derivation of parameter estimates: the estimates are the ones that maximize the likelihood (the continuous generalization) that the data (the observed covariances) were drawn from this population” (Rex; p. 112). Said another way, the maximum likelihood estimators estimate how likely it is that the data obtained is representative of the population. In step three of SEM, the observed matrix is compared to the implied covariance matrix, which is calculated through iteration. A residual matrix, or the differences between the observed matrix and the calculated implied covariance matrix, is also calculated. Iteration continues until the residual matrix cannot be minimized any further, meaning that estimation has converged (Hoyle).

The fourth step is model testing, which tests how well the proposed model fits the data. This is tested most commonly by using the χ^2 goodness-of-fit test, where smaller values are indicative of a better fit. A χ^2 value of zero indicates a perfect fit (Hu & Bentler, 1999). In addition to using the χ^2 goodness-of-fit test, this researcher will also use the Root Mean Square Error of Approximation (RMSEA), the Standardized Root Mean Residual (SRMR), and the Comparative Fit Index (CPI) (Hu & Bentler). The fifth and final step in SEM is model modification, which is where estimated models are adjusted either by fixing parameters (at either

1 or 0) that were previously free parameters, or by freeing parameters that were previously fixed. Model modification occurs if the fit of the model is not sufficient (Hoyle, 1995).

There were specific benefits to using SEM in this study over other statistical procedures. Using SEM allowed this researcher to determine the degree of fit for the whole model, meaning that it allowed this researcher to see how the variables interacted with each other, and how strong this interaction was (Weston & Gore, 2007). As Weston and Gore point out, another advantage of using SEM is that it allows researchers to test the relationships between constructs since latent variables are often constructed from more than one measure. In addition, using SEM allowed this researcher to use multiple predictor variables, multiple mediators, and multiple outcome variables (Weston & Gore). In this study, there were two mediators that were tested- gender role conflict and stigma. There were also two outcome variables- attitudes towards seeking psychological help and willingness to seek psychological help. Similarly, measurement error was reduced when using SEM through the use of confirmatory factor analysis (CFA).

In order to determine whether there were differences in scores on the help-seeking measures based on the placement of the Gender Role Conflict Scale, a between subjects one-way Analysis of Variance (ANOVA) was conducted. A one-way ANOVA was used in order to test the differences in mean scores between different levels of a specific factor, which in this case was GRCS (Maxwell & Delaney, 2004). This researcher compared the mean scores of participants' responses between all three groups. The null hypothesis was that there were no differences in mean scores across all three groups ($H_0: \mu_1 = \mu_2 = \mu_3$). The alternative hypothesis was that the mean scores between all three groups are not equal ($H: \mu_1 \neq \mu_2 \neq \mu_3$). Since the overall F test was statistically significant, the primary investigator used Tukey procedure in order to test all pairwise comparisons.

Chapter IV

RESULTS

Descriptive Statistics

Table 1 shows means, standard deviations, and zero-order correlations for the seven measured variables. The correlations among the majority of the variables were statistically significant. This suggests that the variables of interest are, in fact, related to some extent. Interestingly, there was not a statistically significant relationship between social support and gender role conflict.

Table 1
Intercorrelations and Descriptive Statistics for Measured Variables

Variable	<i>M</i>	<i>SD</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
1. Social Support	4.17	1.56	--	-.29**	-.19**	-.03	-.05	-.33**	.10
2. Quantity	2.11	.79		--	-.13	.07	-.31**	.14	.21**
3. Self Stigma	2.37	.39			--	.14*	.28**	.02	.23**
4. Public Stigma	2.18	1.10				--	.06	.05	.20**
5. Attitudes	2.48	.52					--	-.12	-.05
6. Intentions	2.45	1.18						--	.10
7. GRC	3.56	.82							--

Note. *N* = 193

* $p < .05$. ** $p < .01$

It was hypothesized that the placement of the Gender Role Conflict Scale would negatively influence one's scores related to attitudes towards help-seeking as well as intentions to seek help (Jones, K.D. & Heesacker, M. 2012). A one-way between subjects ANOVA was conducted to compare the effect of placement of the Gender Role Conflict Scale (GRCS) on help-seeking measures. An analysis of simple effects showed there was a significant effect of the placement of the GRCS on responses to help-seeking measures at the $p < .05$ level for the three

conditions [$F(2, 189) = 13.661, p = 0.00$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the condition where the GRCS was in the beginning ($M = 2.30, SD = 0.39$) was significantly different than the condition where it came at the end ($M = 2.83, SD = 1.08$), suggesting that those who responded to the GRCS first endorsed more negative attitudes on the ATSPPHS than those who responded to the GRCS last. Additionally, the mean score for the condition where the GRCS was in the middle ($M = 2.26, SD = 0.36$) was also significantly different than the condition where it came at the end ($M = 2.83, SD = 1.08$), suggesting that those who responded to the GRCS in the middle of the survey endorsed more negative attitudes on the ATSPPHS than those who responded to the GRCS last.

Tested Mediated Models

As previous research has demonstrated, it is possible for self-stigma to serve as a link between gender role conflict and attitudes towards seeking psychological help. It is also possible, based on theory and past research, for social support to serve as a mediator between gender role conflict and attitudes towards help-seeking. This study used SEM in order to test both models in order to create models with the best fit. There are two modeling steps in SEM: creating and testing the measurement model and then testing the structural model (Kline, 2011).

Measurement model. The measurement model is used in order to examine the relationships between latent variables and indicators. Said another way, the measurement model tests how well the measures measure the latent variables (Kline, 2011). The measurement model was tested using SPSS AMOS (Version 23, SPSS). In order to determine the goodness of fit of the models, the chi-square statistic, the comparative fit index (CFI), and the root mean square error of approximation (RMSEA) were used. For the CFI, a value close to .90 or greater indicates a good fit. For the RMSEA, a value of .08 or less indicates good fit. The CFA of the initial model

indicated a poor model fit of the measures to the data. The CFA of the GRCS indicated poor fit of the measures ($\chi^2 = 1443.94$, $df = 104$, $CFI = .30$, $RMSEA = .26$). The CFA of the Self-Stigma subscale of the MSS indicated poor fit ($\chi^2 = 101.69$, $df = 9$, $CFI = .74$, $RMSEA = .23$). The CFA of the MDSS indicated moderate fit ($\chi^2 = 632.42$, $df = 54$, $CFI = .79$, $RMSEA = .24$). The CFA of the ATSPPH scale indicated poor fit ($\chi^2 = 509.10$, $df = 35$, $CFI = .53$, $RMSEA = .27$).

It became clear at this point that not all of the measures were functioning reliably for this specific population. As such, reliability analyses were conducted in order to identify items that loaded onto the variables of interest. Coefficient alphas were also used in order to identify strong factor loadings. After identifying the strong factor loadings, composite variables were created in place of latent variables. Composite variables are created through imputation, which is the process of combining two or more variables to produce one variable or score (Kenny, 2012). Since composite variables were used in place of latent variables, path analysis was used in order to examine the relationship between the variables.

Path analysis resulted in poor fit to the data ($\chi^2 = 28.47$, $df = 1$, $CFI = .61$, $RMSEA = .38$, 90% Confidence Interval [CI] = .27, .50; SRMR = .12). Although a second CFA was conducted, it is possible that the poor fit still resulted from poor construction of the composite variables. It is also possible that the low number of participants may also have negatively influenced the fit of the model. As such, the paths were still examined and interpreted. Consistent with the initial hypothesis, Gender Role was positively and significantly related to self-stigma ($\beta = 0.18$, $p = .013$). Contrary to the original hypothesis, Gender Role Conflict was positively and significantly related to Attitudes towards Help-Seeking ($\beta = 0.29$, $p < .001$). In addition, self-stigma was positively and significantly related to Attitude ($\beta = 0.38$, $p < .001$). The relationship between Gender Role Conflict and Attitude was partially mediated by Self-Stigma, meaning that the path

from GRC to Attitudes was reduced with the inclusion of Self-Stigma. Consistent with the initial hypothesis, Gender Role was negatively related to Social Support, but the relationship was not significant ($\beta = 0.18$, $p = .013$). Additionally, Social Support was negatively related to Attitude ($\beta = 0.18$, $p = .013$) and this relationship was not significant as well. Contrary to the original hypothesis, Social Support did not mediate the relationship between GRC and Attitudes.

Chapter V

DISCUSSION

This chapter will start with an overview of the purpose of the present study, followed by the results of the study integrated with the current literature. Then a discussion of the limitations will be presented. Last, implications of the findings for help-seeking and suggestions for future research are offered.

The purpose of the current study was to expand on previous help-seeking research by using structural equation modeling in order to examine how gender role conflict, stigma, and social support influence attitudes and intentions to seek help for male service members. Structural Equation Modeling (SEM) was used in order to create a model that allowed this researcher to examine the relationships between the variables of interest. The structural model provided a poor fit to the data. Paths were still analyzed because it is possible that the poor fit was due to sample size or measurement of the constructs of interest. This study also served to add to previous research on the use of the Gender Role Conflict Scale as a microcontextual prime. Through the use of a one-way ANOVA, this study provides empirical support for the idea that the GRCS may, indeed, prime an individual and cause changes in their responses to other psychological measures. This demonstrates the importance of being mindful of the measures used in one's study and the placement of said measures.

It was hypothesized that social support would mediate the relationship between gender role conflict and help-seeking. The data did not support this hypothesis. This may be due to the low number of participants in the study. It is also possible that the constructs were not accurately measured in this study. It was also hypothesized that stigma would mediate the relationship between gender role conflict and help-seeking. Self-stigma did partially mediate the relationship

between gender role and attitudes towards seeking help, but contrary to the initial hypothesis, the relationship was positive. This suggests that as one's gender role conflict and self-stigma increase, so do their attitudes towards seeking psychological help. It is possible that the positive relationship between restrictive emotionality and attitudes towards help-seeking was caused by a suppressor variable. According to Frazier, Tix, and Baron (2004), suppression occurs "when the relation between a predictor and outcome becomes larger when the suppressor variable is included in the equation" (126). For example, research has demonstrated relationships between restrictive emotionality, social support, and psychological distress (Wester, Christianson, Vogel, & Wei, 2007). More specifically, Wester et al. (2007) found that psychological distress mediated the relationship between RE and RABBM and social support. Since psychological distress was not evaluated in this study, it is possible that it was somehow impacting the relationship between RE/RABBM and social support.

In their article on factors that influence one's avoidance of counseling, Vogel, Wester, and Larson (2007) discuss several factors that may cause individuals to avoid counseling. Specifically, they mention stigma, fears of treatment, fears of emotion, anticipated benefits and risks, and self-disclosure (410). Of those five avoidance factors, only stigma was assessed in this study. The authors also briefly discuss the role of self-esteem in help-seeking. They note that self-esteem "has been reported to be an importance psychological barrier to seeking help from nonprofessional sources such as family and friends" (413). Again, self-esteem was not measured in this study, but since many participants noted that they did have nonprofessional sources in their lives to which they turned, it is possible that their self-esteem was high enough where they would be willing to seek help if they needed to do so.

Vogel, Wester, and Larson (2007) also discuss how the type of problem an individual is facing may influence their decisions to seek help. More specifically, the authors discuss how seeking help from a primary care physician may be less stigmatizing because “medical issues are not their ‘fault’” (415). It is possible that for the current sample, even if they held stigmatizing beliefs about counseling, they might not see these issues as their fault since it was a result of their participation in the military. Furthermore, there has been a greater push in the military to de-stigmatize the use of psychological services in the past several years, so it is possible that they saw the benefit in utilizing psychological services (Danforth & Wester, 2014).

It is also possible that the results were due to a measurement error. Most of the measures used in this study were normed on traditional college students. While this study was comprised of college students, it targeted non-traditional students whose values differ from those of traditional students. It is possible, then, that measures that typically do well with college populations (i.e. GRCS, ATSPPHS, ISCI) would not accurately measure the same constructs with this population. Similarly, the Military Stigma Scale was normed on active duty soldiers, so it may not take into account certain student-related factors that might influence stigma. Future research should work on creating- and norming- measures for military populations and specifically for students. While there is no evidence of random responding and the data was only slightly skewed, it is possible that participants were less than honest when completing the survey.

It was hypothesized that the Gender Role Conflict Scale could serve as a microcontextual prime, thereby influencing the scores on the ATSPPH scale. Through the use of a one-way ANOVA, this study provides support that the GRCS does, indeed, act as a prime. This study found that there was a significant effect of the placement of the GRCS on responses to help-seeking measures. Jones and Heesacker (2012) suggest that the GRCS might, itself, serve as a

microcontext, but did not test it in their study. The results in this study suggest that the Gender Role Conflict Scale might, indeed, serve as a microcontext in that it might have an effect on responses to help-seeking measures by merely being administered. Specifically, the results from this study suggest that when the GRCS is taken before help-seeking measures, it produces more negative attitudes towards help-seeking. According to Jones and Heesacker, giving the GRCS might prime participants because it causes them to focus on traditional masculine gender roles. That being said, if the GRCS is used in a battery of measures, it is possible that its placement may influence how participants respond to other measures. Further research is needed in order to provide further support for this idea.

Limitations, Implications, and Future Research

One limitation to this study was the use of snowball sampling. As Browne (2005) points out, studies examining certain populations “have employed individuals’ social networks in order to access ‘hard to reach’ and ‘sensitive’ populations” (48). As such, snowball sampling has often been used in order to tap into said populations. While snowball sampling is useful in order to access harder to reach populations, it can be problematic as well. Snowball sampling produces biased samples since “it is not random and it selects individuals on the basis of social networks” (51). Taking that into account, it is possible that the results in this study were somehow skewed by the sample. Future research may want to utilize random sampling in order to better test the relationships between the variables of interest.

Another factor that must be taken into consideration is the heterogeneity of the sample in this study. Not only was there a range of ages that were represented, but there was also a wide range of ranks. Furthermore, all military branches were represented in the study. Samples used in previous research looking at veterans and active duty service members (i.e. Blais & Renshaw,

2013; Plach & Haertlein Sells, 2013) tended to be more homogeneous, thereby making it easier to interpret. Since the sample in this study was so heterogeneous, it made it more difficult to interpret and generalize since there might have been significant differences in responses due to military branch, length of service, or experience of participants.

Another notable limitation of this study was the measures used. Given the unique experiences of active duty service members and veterans, future research should also focus on creating measures specifically for military members. For example, while the Gender Role Conflict Scale has been normed on many male populations, it did not seem to accurately capture gender role conflict in the service members in this sample. Additionally, the Military Stigma Scale did not seem to capture public-stigma and self-stigma in this sample. Creating measures specifically for veterans and active duty service members will allow future researchers to better understand the distinct challenges faced by this population.

While it was not a specific focus of the current study, it is interesting to note that the majority of participants (approximately 97%) opted to donate their earnings from this study to either MAVRC or the Wounded Warrior Project. Future studies may want to specifically examine whether or not a greater sense altruism affects attitudes towards help-seeking. Perhaps framing help-seeking as also being able to help others would encourage individuals to seek help. Furthermore, future efforts to increase help-seeking should consider utilizing campaigns designed to de-stigmatize towards seeking professional help. For instance, the Real Men. Real Depression Campaign was created as a way to de-stigmatize men's perceptions of depression. The campaign focused on providing psychoeducation to men about what depression is, symptoms of depression commonly experienced by men, challenging men's perceptions of help-seeking, and tried to consistently incorporate traditional masculine norms and values (Rochlen,

Whilde, & Hoyer, 2005). Similar campaigns designed to provide psychoeducation and challenge stereotypes- while incorporating traditional masculine norms- could be created for veterans and active duty service members.

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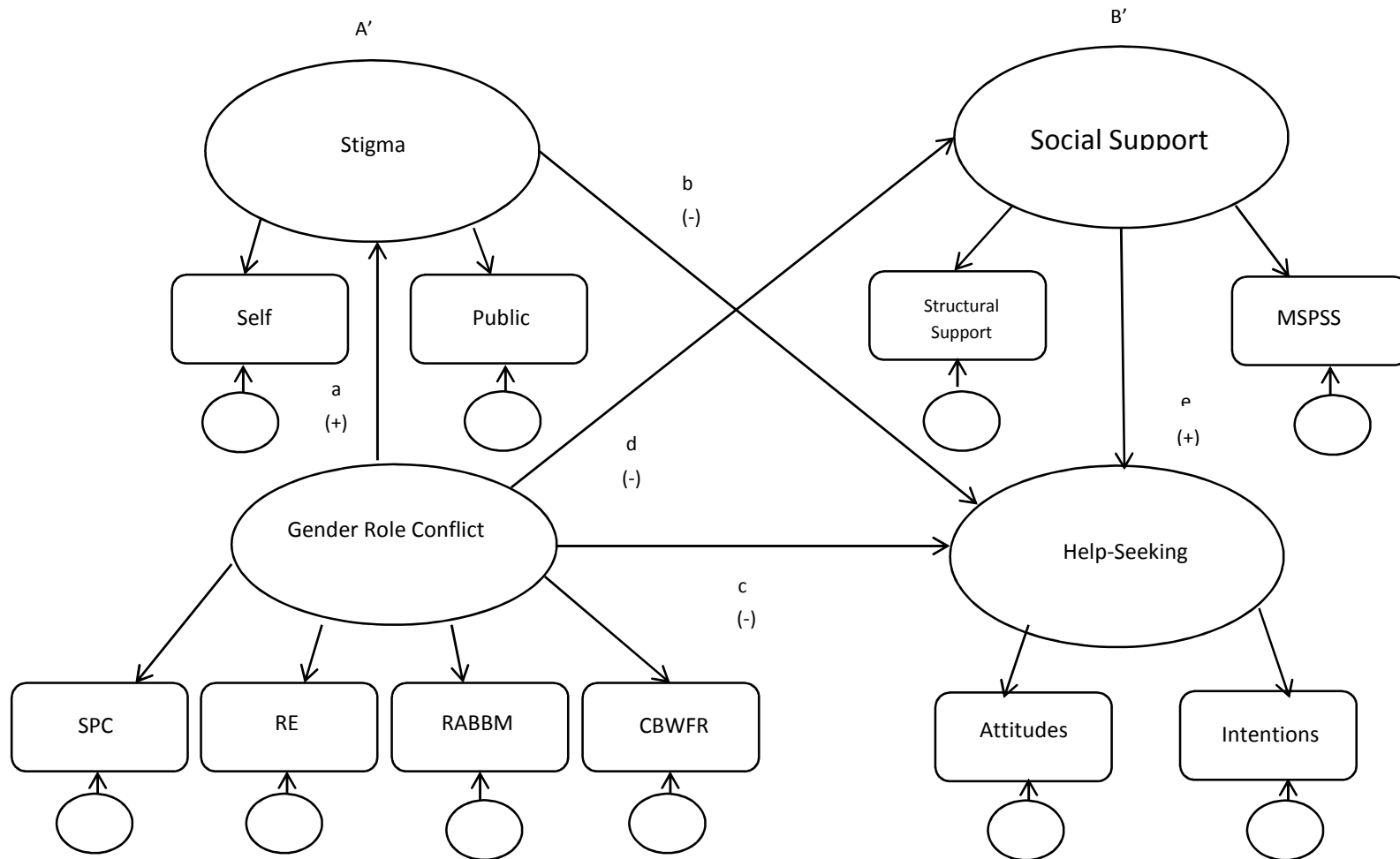


Figure 1. Hypothesized model specification. Ovals represent latent variables. Rectangles represent observed variables. They are connected by arrows. Small circles represent the error terms associated with each observed variable.

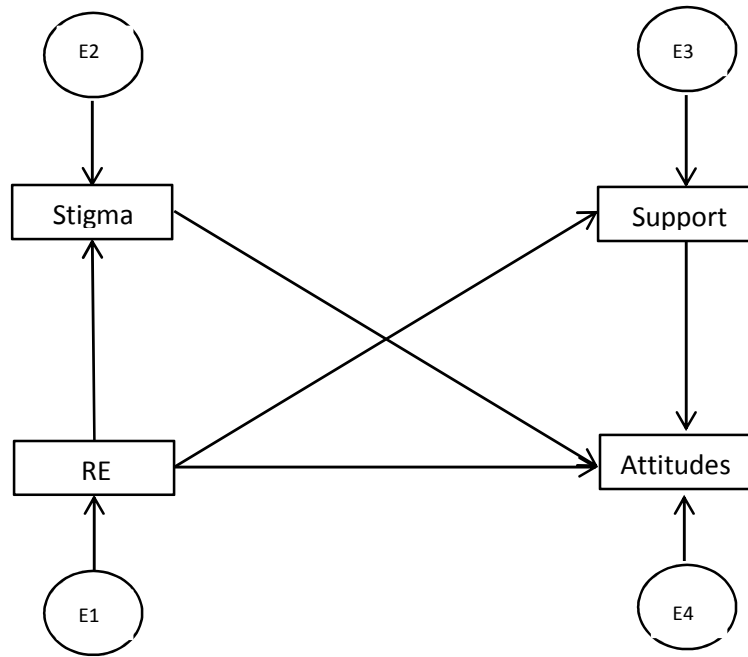


Figure 2. Hypothesized model after second model specification. Rectangles represent composite variables. They are connected by arrows. Small circles represent the error terms associated with each observed variable.

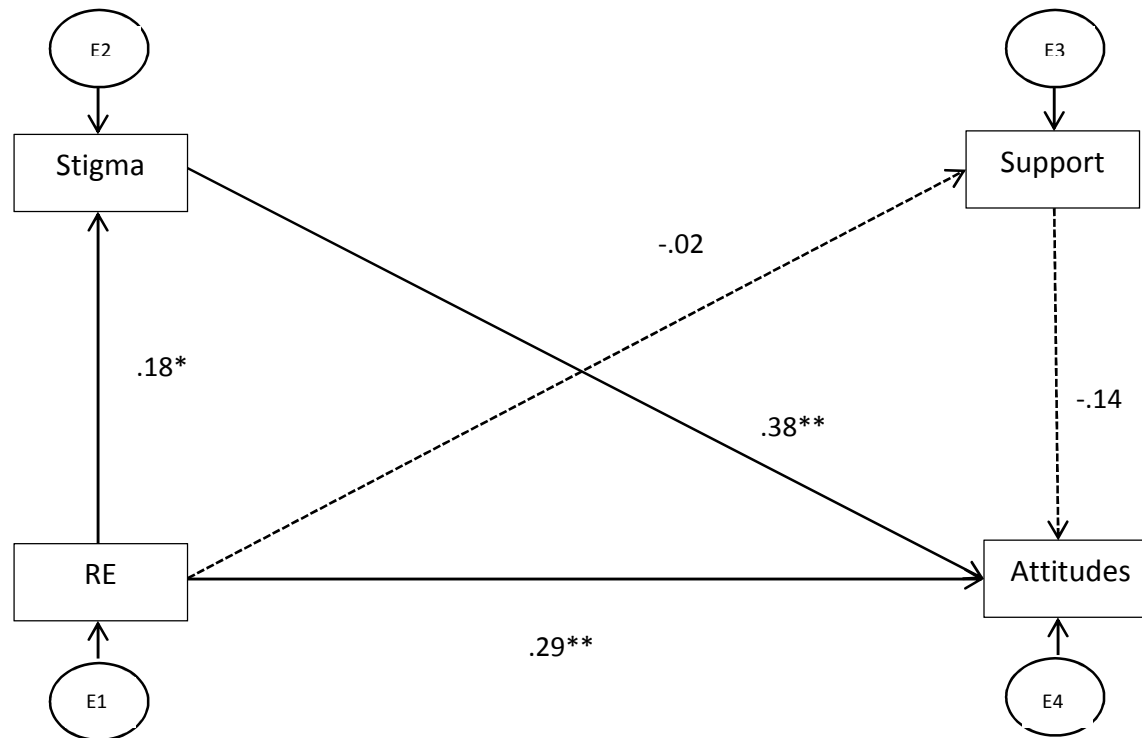


Figure 3. Final mediated model. $N = 193$. The dashed lines indicate paths that were not significant. The numbers represent path coefficients for the indicated paths.

* $p < .05$ ** $p < .01$

APPENDIX D Demographics Questionnaire

Demographics Questionnaire

Age: _____

1. Gender:
 - a. Male
 - b. Female
2. Race/Ethnicity
 - a. Hispanic or Latina
 - b. African-American
 - c. Asian American
 - d. Native Hawaiian or other Pacific Islander
 - e. Caucasian/White
 - f. American Indian/Alaska Native
 - g. Other _____
3. Marital Status
 - a. Single
 - b. Married
 - c. Separated
 - d. Divorced
 - e. Widowed
4. Living Status
 - a. Alone
 - b. With roommate
 - c. With parents
 - d. With spouse/significant other
5. Do you have any children?
 - a. Yes
 - b. No
6. If question 6 was answered yes, how many children do you have and what are their ages?

7. Are you a student?
 - a. Yes
 - b. No
8. Are you working?
 - a. Yes, full time
 - b. Yes, part time
 - c. No

9. If yes to question 9, are you working in your desired career?
- a. Yes
 - b. No

10. What Branch of the Military were/are you in?
- a. Army
 - b. Navy
 - c. Air Force
 - d. Marine
 - e. Coast Guard

11. Which of the following were you or currently are?
- a. Active Service
 - b. National Guard
 - c. Reserves
 - d. ROTC

12. What rank were/are you?

13. What age were you when you entered the Military?

14. Do you smoke?

- a. Yes
- b. No

15. What was/is your M.O.S. (Military Occupations Specialty) and name? Please describe.

16. Was what you did in the military the same as your M.O.S.? If not, what did you do?

17. Have you been deployed? (If no, you are finished with this survey.)

- a. Yes
- b. No

18. If yes to question 18, how many times were you deployed?

19. If yes to question 18, how long were your deployments?

20. Where did you serve? (Circle all that apply)

- a. OEF
- b. OIF
- c. OND

21. Did you receive any of the following?

- a. Combat Action Ribbon (Marines)
- b. Combat Infantry Badge (Army)
- c. Expeditionary Medal
(Navy)
- d. Other

22. If you feel comfortable sharing, what occurred to receive this honor?

23. How long have you been back from a war zone and into your civilian world?

24. Have you received any type of behavioral health treatment since you returned from OEF/OIF/OND?

- a. Yes
- b. No

25. If you feel comfortable sharing, what type of treatment did you receive and did you find it to be helpful?

26. Have you been in a motor vehicle accident since you have been home from the military?

- a. Yes
- b. No

APPENDIX E Gender Role Conflict Scale- Short Form

Gender Role Conflict Scale-Short Form

Instructions: In the space to the left of each sentence below, write the number that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

Strongly Agree 6	5	4	3	2	Strongly Disagree 1
1. ____ Finding time to relax is difficult for me.					
2. ____ Winning is a measure of my value and personal worth					
3. ____ Affection with other men makes me tense.					
4. ____ I like to feel superior to other people.					
5. ____ Talking about my feelings during sexual relations is difficult for me.					
6. ____ I have difficulty expressing my emotional needs to my partner.					
7. ____ Men who touch other men make me uncomfortable.					
8. ____ I have difficulty expressing my tender feelings.					
9. ____ Hugging other men is difficult for me.					
10. ____ My needs to work or study keep me from my family or leisure more than would like.					
11. ____ I strive to be more successful than others.					
12. ____ I do not like to show my emotions to other people.					
13. ____ My work or school often disrupts other parts of my life (home, family, health leisure.					
14. ____ Being very personal with other men makes me feel uncomfortable.					
15. ____ Being smarter or physically stronger than other men is important to me.					
16. ____ Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life.					

APPENDIX F Multidimensional Scale of Perceived Social Support

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Very Strongly Disagree			Neutral			Very Strongly Agree
7	6	5	4	3	2	1

1. ____ There is a special person who is around when I am in need.
2. ____ There is a special person with whom I can share my joys and sorrows.
3. ____ My family really tries to help me.
4. ____ I get the emotional help and support I need from my family.
5. ____ I have a special person who is a real source of comfort to me.
6. ____ My friends really try to help me.
7. ____ I can count on my friends when things go wrong.
8. ____ I can talk about my problems with my family.
9. ____ I have friends with whom I can share my joys and sorrows.
10. ____ There is a special person in my life who cares about my feelings.
11. ____ My family is willing to help me make decisions.
12. ____ I can talk about my problems with my friends.

APPENDIX G Structural Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

At least once a day	At least once a week	At least once a month	Less than once a month	Not at all
----------------------------	-----------------------------	------------------------------	-------------------------------	-------------------

1. In the past 12 months, how often did you talk to a family member (including a quick phone call or email)? _____

2. In the past 12 months, how often did you do things with any close friends (even a quick phone call or encounter)? _____

APPENDIX H Military Stigma Scale

Military Stigma Scale

Instructions: Please choose the response that best matches how much you agree or disagree with each statement. **There are no right or wrong answers.** Circle the number that is right for you.

DEFINITION: *A mental health provider* is a licensed professional who deals with psychological problems or issues that people sometimes have (e.g. psychologist, psychiatrist, licensed counselor, social worker). *Psychological problems* are reasons a person would go to a mental health provider. Similar terms include *mental health issues*, *psychological issues*, *mental troubles*, *mental health concerns*, and *emotional problems*.

Please use the 4-point scale to rate the degree to which agree or disagree with each statement.

Definitely Disagree 4	Somewhat Disagree 3	Somewhat Agree 2	Definitely Agree 1
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1. ____ My self-confidence would be harmed if I got help from a mental health provider.
2. ____ I would be given less responsibility, if my chain of command knew I was seeing a mental health provider.
3. ____ If my chain of command discovered I was seeing a mental health provider, I would NOT lose their respect.
4. ____ People would judge me poorly if they knew that I received mental health services.
5. ____ I would worry about my personal problems being part of my military records.
6. ____ People I respect would think less of me if they knew I had mental health problems.
7. ____ My view of myself would change if I made the choice to see a therapist.
8. ____ My chances of promotion would be harmed if I sought mental health services.
9. ____ I would feel okay about myself if I made the choice to seek professional help.
10. ____ I am open to seeking services, but I worry about how it could hurt my career.
11. ____ My reputation in my community would be harmed if people knew that I had seen a mental health provider.
12. ____ I would be afraid that my peers would find out what I tell my mental health provider.
13. ____ I would feel worse about myself if I could not solve my own problems.
14. ____ It would make my problems worse if my peers knew I was seeing a mental health provider.

15. ____ I would feel inadequate if I went to a therapist for psychological help.
16. ____ Seeking psychological help would make me feel less intelligent.
17. ____ My peers would think less of me if they knew I was getting help from a mental health provider.
18. ____ If I went to a therapist, I would be less satisfied with myself.
19. ____ I'd lose the respect of my subordinates if they found out I was receiving mental health care.
20. ____ There are things I am afraid to talk about because of what others would think.
21. ____ A person seeking mental health treatment is seen as weak.
22. ____ It would make me feel inferior to ask a therapist for help.
23. ____ I am afraid that my chain of command would find out what I told a mental health provider.
24. ____ My peers would think I was unreliable if they knew I was receiving mental health treatment.
25. ____ My self-confidence would NOT be threatened if I sought professional help.
26. ____ My self-esteem would increase if I talked to a therapist.

APPENDIX I Attitudes Towards Seeking Professional Psychological Help Scale- Short Form

Attitudes Towards Seeking Professional Psychological Help Scale- Short Form

Instructions: To what extent do you agree or disagree with the statements below:

Disagree 4	Partly Disagree 3	Partly Agree 2	Agree 1
---------------	-------------------------	----------------------	------------

1. ____ If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. ____ The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts
3. ____ If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy
4. ____ There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.
5. ____ I would want to get psychological help if I were worried or upset for a long period of time.
6. ____ I might want to have psychological counseling in the future.
7. ____ A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.
8. ____ Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. ____ A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. ____ Personal and emotional troubles, like many things, tend to work out by themselves

APPENDIX J Intentions to Seek Counseling Inventory

Intentions to Seek Counseling Inventory

Instructions: Below is a list of issues people commonly bring to counseling. How likely would you be to seek counseling if you were experiencing these problems?

	Very unlikely	Unlikely	Likely	Very likely
1. Weight control	1	2	3	4
2. Excessive alcohol use	1	2	3	4
3. Relationship differences	1	2	3	4
4. Concerns about sexuality	1	2	3	4
5. Depression	1	2	3	4
6. Conflict with parents	1	2	3	4
7. Speech anxiety	1	2	3	4
8. Difficulties dating	1	2	3	4
9. Choosing a major	1	2	3	4
10. Difficulty in sleeping	1	2	3	4
11. Drug problems	1	2	3	4
12. Inferiority feelings	1	2	3	4
13. Test anxiety	1	2	3	4
14. Difficulty with friends	1	2	3	4
15. Academic work procrastination	1	2	3	4
16. Self-understanding	1	2	3	4
17. Loneliness	1	2	3	4

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